IN THE CIRCUIT COURT OF WASHINGTON COUNTY, MISSISSIPPI

JEANETTE WILKS, DAUGHTER OF ANDERSON SMITH, DECEASED, INDIVIDUALLY, AND ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES AND THE ESTATE OF ANDERSON SMITH, DECEASED	*	CIVIL ACTION
	*	FILE NO. 91-12,355(b)(w)
Vs.	*	
THE AMERICAN TOBACCO COMPANY AND NEW DEAL TOBACCO AND CANDY, INC.	*	

Property of Ness, Motley
Main PI File Room
Charleston, SC

DEPOSITION OF
JAMES ALLEN REINARZ, M.D.

DEPOSITION OF JAMES ALLEN REINARZ, M.D., was taken on the 9th day of February, 1993, at the Holiday Inn, Seawall Blvd., Galveston, Texas, beginning at the hour of 1:00 p.m., pursuant to notice.

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JAMES ALLEN REINARZ, M.D.

was called as a witness and, having been duly cautioned and sworn, was examined and testified upon his oath as follows:

EXAMINATION

By Mr. Scruggs:

Q. Doctor, state your full name for the record.

A. James Allen Reinarz.

Q. What's your residence address?

A. It's [DELETED]

Q. Did you grow up in the [DELETED]

A. I've grown up everywhere. I was born in San Antonio and went through a bunch of little Texas towns. I call Austin home; it's where I went to high school and university. And I came here to medical school. Went to Anarbor for internship. Came back here for residency. I went to Southwestern for fellowship in infectious diseases. And I was in San Antonio in the Air Force for seven years, and I've been here since 1971.

Q. Doctor, did you bring any documents with you today?

A. Just these. And this. This is my heart and soul.

Q. You pointed to two notebooks, one large and one small.

A. These are the medical records of Mr. Smith. This is my calendar.

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Q. Let me ask you some general questions, then.

A. Yes.

MR. SCRUGGS: Let's mark as Exhibit 1 the large black notebook that you indicated were medical records of Mr. Smith.

(Reinarz Deposition Exhibit No. 1 marked for identification.)

Q. (By Mr. Scruggs) Now, what is exhibit -- I'm sorry, the other small notebook you said is your calendar?

A. Yes.

Q. This is your personal --

A. It's got phone numbers and dates. Yeah, it's just -- you're free to look through it, if you like.

Q. Is this calendar something that you --

A. It's just I don't like to be without it, in case I have to make a phone call or something.

MR. BAILEY: It's not produced pursuant to the agreement.

A. It has nothing to do with this case.

Q. (By Mr. Scruggs) It's not something you showed the lawyers who asked you to be here today?

A. Huh-uh.

Q. Okay. Does it have any notes of conversations with these lawyers?

A. No, not really.

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Q. Not really or not at all?
A. It's got schedule things in there.
Q. All right. Did you write any notes down after -- in this small notebook after conferring with the lawyers --
A. No.
Q. -- that are here today?
A. No.

MR. SCRUGGS: It's my understanding, Counsel, that this notebook has nothing to do with this case or his testimony?

MR. BAILEY: That notebook was not produced pursuant to subpoena.

Q. (By Mr. Scruggs) It's something you take with you everywhere you go, like you take your wallet and your beeper and your car keys? Okay. Fine.

Doctor, does Exhibit 1, do the documents contained in Exhibit 1, represent or are they all of the documents that you reviewed in connection with the testimony that you will give in this case?

A. That I specifically reviewed for the purpose of giving testimony, yes.

MR. BAILEY: Can I interrupt you for a minute? What's your intention with respect to the custody of Exhibit 1?

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MR. SCRUGGS: To have the court reporter attach it as Exhibit 1 to the transcript of this testimony.

MR. SHEFFLER: Can we go off the record?

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, I'm going to go over a list of documents that we asked the defendants to produce in the case. And this is strictly -- I'm just going to read to you from this document sheet and ask you if you have produced all the documents that you know of that fall into these categories.

The first category will be all documents and materials given to you by the lawyers that asked you to be here today, that is the lawyers for American Tobacco Company, concerning Anderson Smith or the case entitled, Wilks versus American Tobacco Company.

A. Yes.

Q. Okay. Are these also all the documents and materials given to the lawyers -- strike that. Did you give any materials or documents to these lawyers to look at?

A. Not that I recall.

Q. Did you allow them to see any documents when they

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visited with you at any time?

A. Not that I recall.

Q. Does Exhibit 1 consist of all the documents that you reviewed concerning Anderson Smith --

A. Yes.

Q. -- for this case?

A. I believe so.

Q. Okay. Some of this is repetitive. I apologize if it is. The fourth category is all documents and materials in your possession concerning Anderson Smith or this case.

A. Yes, uh-huh.

Q. Fifth category is all documents and materials relied upon by you in reaching opinions in the Anderson Smith case.

A. Well, you have to think of my composite medical experience in giving opinions, but anything specifically done for that purpose, no.

Q. All right. The sixth category is all written reports including all drafts and notes of opinions that are set forth in this document, which we will mark as Exhibit 2.

(Reinarz Deposition Exhibit No. 2 marked for identification.)

Q. (By Mr. Scruggs) Take a look at Exhibit 2 and see

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if you can identify it, Doctor.

A. I'm aware of this. I've seen it, yes.

Q. Where did you first see this Exhibit 2?

A. I think it was read to me and we discussed it or talked with Mr. Sheffler about it several months ago, and I think I've seen it one other time.

Q. Doctor, did Mr. Sheffler or any of the lawyers for American Tobacco, Mr. Sheffler's colleagues, send you a draft of this document that is different from the one that is before you today as Exhibit 2?

A. I don't believe so.

Q. Did they ask you to review Exhibit 2?

A. Uh-huh.

Q. Did you do so?

A. Just like you did, yes.

Q. All right.

A. I mean, I don't know whether it was reviewed by reading it or listening to it be read to me, but I certainly don't have any problem in agreeing to that.

Q. Did you suggest any changes?

A. Not that I recall.

Q. Did you make any notes of your conversations?

A. I don't believe so, no.

Q. Do you have any other drafts or copies of Exhibit 2?

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A. No.
Q. Did you write a report or a letter to the lawyers for American Tobacco about this case?
A. I don't believe I did.
Q. Did you dictate one to them over the telephone?
A. I don't believe I did.
Q. Did the lawyers for American Tobacco Company communicate in writing to you in any way?
A. I don't recall any real communication in writing, really. We've talked.
Q. Just mostly telephone and face-to-face conversations?
A. Yes.
Q. I'm asking --
A. I honest to God really don't know. By no means a lot of communication, if there was any.
MR. SHEFFLER: What he's asking is did we send you any correspondence or did you send any correspondence to us?
A. I do not believe I did.
Q. (By Mr. Scruggs) And if you did, you would have produced it in Exhibit 1?
A. Yeah. And I'm surely not trying to hide anything.
Q. Nor am I suggesting you are. I just want to be sure that I know all the communications in writing

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between you and the lawyers for American Tobacco. It's that simple.

A. I understand.

Q. Do you have any documents that concern the Tobacco Research Committee, the Counsel for Tobacco Research, the Tobacco Institute or the American Tobacco Company?

A. Not that I specifically sought out. I get a lot of stuff in the mail, and I won't say I never received it, but I have made no effort to accumulate that or review it or make it any part of this record.

Q. And you don't know whether you have any of that in your possession now or not?

A. No, sir.

Q. Do you have any documents or have you had any documents that concern cigarette advertising?

A. No, sir.

Q. Do you have any documents or have you had any documents in your possession concerning public relations in cigarette companies?

A. No, sir.

Q. Do you have now or have you ever had documents in your possession concerning the risks of smoking cigarettes?

A. Only as part of standard medical textbooks.

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Q. Have you billed or sent a statement to the attorneys for American Tobacco or to American Tobacco Company for your services in this case?
A. Not for any services, no, sir.
Q. Have you compiled such a bill?
A. No.
Q. Have you compiled a log of your time spent on this case?
A. Crudely, yes.
Q. Where would that be? Where would that exist?
A. Basically on my calendar at home, or calendar at the office.
Q. Is that the only place a record of your time spent on this case would exist?
A. Yes, it would.
Q. Do you intend to send them a bill?
A. I believe I will, yes.

MR. SCRUGGS: Bruce, I take it that you will send us the bill when he sends it to you?

MR. SHEFFLER: If the application is made to do so, we'll respond to it appropriately.

MR. SCRUGGS: It is my understanding that the doctor was to have brought these

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bills with him today, and just the fact that he has not yet prepared one but has a [illegible] or crude copy of such on his calendar --

THE WITNESS: I don't even have that, just a crude record of when we talked.

MR. SHEFFLER: That's fine.

MR. SCRUGGS: That's, as I understand it, within the scope of what we asked him to bring today, and yet he has not brought it today. Therefore I'm asking that that be produced.

MR. SHEFFLER: I tell you what, there may be other things like that through the course of the deposition. It's been our practice at least to put those down in a letter and articulate in the letter exactly what you're seeking and send that to me.

MR. SCRUGGS: As you know, I'm new in the case. So I refer to Mr. Barrett on that one.

MR. SHEFFLER: I don't care who writes it down. To be honest with you, I'm not going to say I'll remember everything that transpires. So if you would, if you have any request further, write it down in a

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letter and send it to us and we'll respond.

Q. By Mr. Scruggs: Doctor, how many hours would you say you have spent so far in this case at the request of the lawyers for American Tobacco?

A. It would have to be a guess.

Q. That would be fine, I'll take a guess.

A. I'd really have a hard -- I really would have a hard time estimating that. To go through this, which I've been through it now three different times --

Q. That is Exhibit 1?

A. Yeah. Probably takes 12, 15 hours to go through it. And I've talked with Mr. Sheffler maybe for a total, in one capacity or another, oh, 20, 24 hours.

Q. Okay. So perhaps 36 to 45 hours in reviewing Exhibit 1?

A. Yeah, probably.

Q. And probably another 20 to 24 hours in discussions with Mr. Sheffler?

A. Probably.

Q. What other categories of time would you have spent in the case besides those two?

A. Well, I think about it. And that would be a rough estimate. That's a guess. I have no idea.

Q. When you prepare a bill to the American Tobacco Company or Mr. Sheffler, how are you going to

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quantify that?

A. I haven't done that.

Q. When you do so, how are you going to --

A. I'll be billing for these and the hours that we talked about.

Q. Will you bill him for the hours you spent thinking about the case?

A. Probably not.

Q. Any other categories of time?

A. Not that I can recall.

Q. Are you billing only for time?

A. Yes.

Q. **What is your hourly rate?**

A. Depends on what I'm doing. Review of medical records, I've got a range between 150 and 250 an hour, depending on the complexity of the medical records. And depositions, gosh, I think that's between 250 and 350, depending on whether or not it's a video deposition and all that. And then court testimony, probably 350 an hour. And I really don't recall what I put for waiting time.

Q. What about time spent discussing the case with Mr. Sheffler?

A. That would be the same as review of medical records.

Q. Between 150 and 250 an hour?

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A. Yes.

Q. What rate do you intend to charge Mr. Sheffler's client for reviewing the medical records of Anderson Smith?

A. I haven't really decided that.

Q. It will be between 150 and 250?

A. Yes.

Q. Are these records what you would consider to be complex medical records?

A. Some are, some aren't.

Q. Which would be complex and which would not be?

MR. SHEFFLER: To the best of your -- well, I object to the form of the question.

A. When you review medical records, you do a lot more than read what's written. I mean, sometimes it's hard to read what's written, first of all. Secondly, you try to put it within the context of what's gone before, what's gone on following, and put yourself in the mind of the person writing the records, whether it's a nurse or a physician, and why are they doing the things they are doing. And then you can actually spend a fair amount of time on one page trying to understand that. Other records can go through like reading a novel.

And so it becomes difficult. The focus on most

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of my effort into the last two hospitalizations for Mr. Smith have been more or less aware of the antecedent events leading up to that. But I have not attempted to put together encyclopedic knowledge like I would a script so I can read it back to you by date or time. But I've tried to understand most of his process of how things happened in the medical area.

Q. What percentage of these records would you estimate would be in the complex category versus the last --

A. Eighty-five percent.

Q. And what percentage of your time would you have -- would you estimate you have spent reviewing the complex records as opposed to the non-complex records?

MR. SHEFFLER: To the best of your ability. He's asking for an estimate, Doctor. Best of your ability.

A. I can't honestly say. I've spent the majority of time doing complex stuff.

Q. (By Mr. Scruggs) More than half?

A. If you want to look at court case, I presume I will be going to trial, and I'm going to be guided in large part by the kind of questions you ask as to where I'm going to address my emphasis. So that if

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you ask me a bunch of questions in an area, I promise you I'll know a hell of a hot more about it in specific detail at the time of trial than I do right now. At this moment, my goal is to understand the overall gestalt, the overall picture of it, rather than being able to recall back encyclopedic detail any part of it.

MR. SCRUGGS: Mark this as Exhibit 3.

(Reinarz Deposition Exhibit No. 3 marked for identification.)

Q. (By Mr. Scruggs) Doctor, I've had marked as Exhibit 3 a copy of your curriculum vitae, which appears to have your name on it.

A. And it's mine.

Q. Is this your most current CV?

A. No, actually, because it's dated 3, January, '90.

Q. It's the most current one we have. Do you have a more current one with you?

A. No, but I'll be happy to provide you one. There is nothing substantively different.

Q. Okay. Doctor, what can you recall that would be different, substantive or not?

A. Oh, God.

MR. SHEFFLER: If you would put that in a letter, we will make sure that you get

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a copy of the new CV. That was an oversight, I'm sorry. We meant to give you -- that unfortunately was produced and at the time it was produced it was current. We will make an effort to do --

MR. BARRETT: Let me ask you this, how far is his office from here?

THE WITNESS: I can have one ready for you to pick up and take out of town. I mean, it is inconsequentially different than that.

MR. SCRUGGS: Let me explore that and we may can go at it that way.

Q. (By Mr. Scruggs) What would you have added to Exhibit 3?

A. I don't know, because I would have to go through and read the whole thing. A number of papers, different committees. Among other things, **Desert Storm** occurred since then; I've been to that. But there is nothing of substantive nature that impacts on this case that's different.

Q. All right. Doctor, have you actually prepared a more recent CV than this, or are you saying that there are things you have done that are not on this CV or any other CV presently?

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A. That's correct. That's exactly what I'm saying.
Q. This is the most recent prepared CV you have, though, Exhibit 3?
A. No, because about every six months we send one to the dean.
Q. All right, sir. So when did you prepare the most recent CV?
A. Let's be totally precise about it. My secretary is the one that prepares it. And when was the last one prepared? Probably two or three months ago.
Q. So your secretary, then, would have a copy in her file right this minute of that CV?
A. Yes. Yes.
Q. How far is your office from here?
A. Depends on whether you talk minutes or miles. About 12 minutes.
Q. Would it be possible to have someone bring it over here?
A. No, unless you want to send someone to pick it up, because she's by herself today. The other one is sick.
Q. It is not our job on this side of the table, Doctor --

MR. BARRETT: Let's go off the record.

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Discussion off the record.

MR. SHEFFLER: Let me make a statement for the record. We, as I told Mr. Scruggs earlier, we will endeavor to get a copy of the most recent curriculum vitae to Mr. Scruggs for Dr. Reinarz. We will do so when Dr. Reinarz has an opportunity to go back and get his secretary to send a copy to Mr. Bailey. Mr. Bailey will forward it to Mr. Barrett or Scruggs or both. We have no intensions of sending anybody to go pick up the curriculum vitae at this time, because we're all involved in the defense of this deposition. And there is no one available in Dr. Reinarz' office to bring the curriculum vitae over here to this deposition. And we're not intending to interrupt his office procedures to do so at this time.

MR. SCRUGGS: Of course we reserve the right to redepose the doctor once the most recent and updated CV is produced.

MR. SHEFFLER: You can reserve anything you want, Mr. Scruggs.

MR. BARRETT: Do you all agree that

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we have an agreement that the most recent CV would be produced today one hour prior to this deposition?

MR. SHEFFLER: I agree you haven't produced CV's for any of your witnesses. Let's go.

MR. BARRETT: Do you agree or do you not agree that we have that agreement? Do we have that agreement or not?

MR. UPSHAW: We've done it. The guys had --

MR. SHEFFLER: This is a waste of time. We're not here to discuss this. Let's continue the deposition.

MR. BARRETT: I'll tell you what we'll do. We'll send somebody over to get it. Would you produce it if we send somebody over to get it?

THE WITNESS: Of course.

MR. UPSHAW: It's going to really shock you when you read Desert Storm.

MR. BARRETT: I'm sure it will.

THE WITNESS: 4.140 McCullough Building.

MR. BARRETT: And where is that?

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THE WITNESS: Right smack in the middle of the campus.

MR. BARRETT: Middle of what campus. I don't know anything about Galveston.

THE WITNESS: That's in the other CV. That's University of Texas Medical Branch Campus.

MR. BARRETT: Okay. Why don't we take a break and let you call your secretary and tell her we're going to be coming to get it.

MR. SHEFFLER: Before we go off the record, is this going to interfere with your office procedures today?

THE WITNESS: No.

MR. SHEFFLER: Because if it is --

THE WITNESS: I think we have a bunch of them ready to go.

MR. SHEFFLER: Let's take a break and call your secretary and make arrangements.

(Brief recess.)

Q. (By Mr. Scruggs) Doctor, have you given sworn testimony in the past?

A. Yes, I have.

Q. On how many occasions?

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A. I don't know.
Q. Fewer than 50?
A. Yes.
Q. Fewer than 20?
A. I think probably fewer than 20. Probably between 10 and 20.
Q. Thank you. Have you given sworn testimony in court?
A. Yes.
Q. How many times in court?
A. A guess, six or seven times.
Q. Best estimate you can give me.
A. Six or seven times.
Q. Six or seven times in court? And how many times by deposition?
A. Probably twice that.
Q. When is the most recent time you testified in court?
A. Oh, I think it was probably in October of 1992.
Q. And when is the most recent time you gave a deposition?
A. Before that.
Q. In connection with the same case?
A. Yes. Several weeks before that.
Q. What type case was it?
A. It was a medical malpractice case.
Q. On each occasion when you've testified in court, was

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it a medical malpractice case?

A. Or some variation off of that, yes.

Q. Well, what do you mean by variation off of a medical malpractice case?

A. I just didn't want to paint myself in a corner and say they are all medical malpractice cases, but they are all medically related cases. I cannot recall a specific that was not.

Q. Were they all cases wherein a plaintiff had filed suit against a doctor or medical establishment?

A. Largely, yes.

Q. Okay. The word "largely" gives me caution.

A. To the best of my knowledge, that's true.

Q. All right. This isn't, again, a memory test, Doctor.

A. It sure sounds like one.

MR. SHEFFLER: He's merely asking for your best recollection. To the extent you can give that, Doctor, please do. To the extent you can't, you can so indicate.

Q. (By Mr. Scruggs) Do you recall testifying in court in any case that did not involve a claim by a plaintiff that he had been -- that a physician or medical establishment had been negligent in his treatment or care?

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A. With the exception of traffic cases and that type of thing that myself was involved in -- well, the reason I answered the question that you ask is I've been through a divorce case myself.

Q. Excluding that.

A. That's not medical malpractice.

Q. No, excluding -- excluding your own personal litigation.

A. I don't believe I have.

Q. So as far as you can remember, then, in every occasion where you've testified in court, other than in litigation involving yourself, it's been in a case of alleged medical malpractice of some sort?

A. Yes.

Q. Would the same be true for the depositions you've given?

A. Yes, I believe so.

Q. In the medical malpractice cases in which you testified in court, were you called to testify by the attorneys for the plaintiff or the defendant?

A. Both.

Q. How many each way?

A. This would represent an estimate, but probably 75 percent defense, 25 percent in favor of the plaintiff.

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Q. I'm sorry, 75 percent of the time you've testified in court it's been at the request of the defendant, and 25 percent at the request of the plaintiff?

A. That may be a little high, but that's a fair statement. There have been at least two or three times that I can recall that I was the witness for the plaintiff.

Q. Would the same be true for the times you've given deposition testimony?

A. Probably. Probably.

Q. Would it be fair to say, then, that you've testified either by deposition or in court more times at the request of a defendant in a medical malpractice case than at the request of the plaintiff?

A. Oh, very much so, yes.

Q. When you gave testimony in court, can you give me the subject matter of the alleged malpractice? What area of the body did it involve? What field of medicine did it involve?

A. Most of it was regarding internal medicine and/or infectious disease areas.

Q. What is internal medicine?

A. Internal medicine is that discipline of medicine that deals with the diagnosis or treatment of illness that does not include surgical procedures.

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Although that's changing somewhat.

Q. What organ was involved in the testimony you gave in court, or what group of organs?

MR. SHEFFLER: Object to the question. I mean, are you -- are you directing your question at any specific case?

Q. (By Mr. Scruggs) No, in the times that you've testified in court as an expert in internal medicine.

A. I testified in one in which the individual had an infected penile prosthesis. I testified in one in which he was a child with meningitis.

Q. Okay.

A. I've testified in another in which there was a pharyngeal abscess that dissected into the mediastinum. Those are the ones that come to mind.

Q. Those were the cases wherein you testified as an expert in internal medicine?

A. Most of those are both infection and internal medicine.

Q. Was lung cancer involved in any of those cases?

A. No.

Q. Bronchitis?

A. I don't believe so.

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Q. Emphysemia, pulmonary emphysemia.
A. No.
Q. You've never testified in court as an expert in thoracic medicine?
A. Well, with the dissection of the pharyngeal abscess into the mediastinum, that involved the whole middle of the chest.
Q. Have you ever testified in court or by deposition as an expert in chronic lung diseases?
A. Not that I recall.
Q. What about neoplasms of the lung?
A. No.
Q. Doctor, you mentioned earlier that you had perhaps had 20 to 24 hours of conversations with Mr. Sheffler. Did you have conversations with any other attorneys?
A. Regarding this case?
Q. Yes.
A. I've talked with these gentlemen here.
Q. Okay. That is the gentlemen present here today?
A. Uh-huh.
Q. Any other lawyers for American Tobacco besides those that are here today?
A. I don't believe so.
Q. On how many occasions, separate occasions, have you

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had discussions with these attorneys about this case?

A. These other gentlemen?

Q. With any of the attorneys present today, including Mr. Sheffler.

A. A guess, probably total of five times.

Q. Five different times? When is the first time you had a discussion?

A. I don't know.

Q. Approximately how long ago was it?

A. Well, it was sometime before January of '90 in which that -- I had met with Mr. Sheffler in another case and it sort of came up in conversation. And we carried on an informal discussion. And then he called me one afternoon and asked me if I would be willing to look at the records in the case.

Q. Dr. -- is it Reinarz? Did I pronounce that properly?

A. Yes, you did.

Q. I mispronounced the lawyer's name and I don't want to do that to the witness.

A. Please.

Q. Dr. Reinarz, on how many occasions has Mr. Sheffler asked you to provide service to him?

MR. SHEFFLER: I object to the form

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of the question.

A. What kind of services?

Q. (By Mr. Scruggs) Medical services, medical opinions.

A. To my knowledge, is this particular case here.

Q. Well, you mentioned you were working on an earlier case with Mr. Sheffler, what did it involve?

A. No, I said that -- there was one other case and it concerned a case that was filed in Louisiana.

MR. SHEFFLER: Maybe I can clear up the confusion. I didn't retain Dr. Reinarz in that case directly, but we did work together on the case, if that helps you.

Q. (By Mr. Scruggs) Did that case involve an allegation of injury from tobacco smoke?

A. Yes.

Q. On how many cases have you worked with Mr. Sheffler or anyone at his firm or any lawyer for a tobacco company other than this case and the case in Louisiana?

A. One other one, I believe.

Q. So there were three --

A. Yeah.

Q. -- altogether?

A. Uh-huh.

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Q. And where did the third one take place? Where was that case pending?
A. Where is it --
Q. Where was it pending? Where was the lawsuit?
A. In Louisiana.
Q. Also in Louisiana?
A. Yes.
Q. Do you remember the cities in Louisiana where those cases were filed?
A. No, sir, I really don't.
Q. Do you remember the names of the plaintiffs in either case?
A. I remember one. That was the Lejeune.
Q. Could you spell that for me?
A. It's L-e-j-e-u-n-e.

THE WITNESS: Do you recall --

MR. SHEFFLER: He's asking you.

Q. (By Mr. Scruggs) L-e-j-u-n-e?
A. L-e-j-e-u-n-e, I think.
Q. Typical Louisiana name.
A. Something like that.
Q. Do you recall the name of the other plaintiff?
A. Not at this moment.
Q. Could it have been Gilboy, G-i-l-b-o-y?
A. Yes, I have been involved in Gilboy.

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Q. Was that the other case?
A. Yes.
Q. Have there been any besides the Lejeune and Gilboy cases?
A. No.
Q. Doctor, have you been asked to consult with a lawyer for a tobacco company in any case other than the Lejeune, Gilboy and Wilks case, which is the case we're here today with Anderson Smith?
A. I don't believe so, sir.
Q. Did you charge the attorneys that retained you for consultation in the Lejeune case according to the same rate that you mentioned you were going to charge in this case?
A. Pretty much, yeah.
Q. The same true with the Gilboy case?
A. Yes.
Q. Can you recall how much work you did in the Lejeune?
A. I have no idea.
Q. Do you recall how much money they paid you in the Lejeune case --
A. I really don't.
Q. -- that is Mr. Sheffler and his colleagues?
A. I really don't.
Q. Do you have records that would indicate that?

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A. I'm sure I do.

Q. Did they provide you with any sort of a tax form when they paid you?

A. I hope so.

Q. Like a 1099 form?

A. Yes. Well, I guess. I don't really know.

Q. Would you have that in your office?

A. No, I wouldn't, because --

MR. SHEFFLER: Objection. He says he really doesn't know if he has it.

A. I don't know whether that -- I have an accountant that I send all that stuff to.

Q. (By Mr. Scruggs) Same thing in the Gilboy case?

A. I have not billed in that case.

Q. Is that still going on?

A. As far as I know. I haven't heard a thing out of it in a long time.

Q. Approximately how much time did you spend in that case?

A. I don't know. I don't have any idea.

Q. Did you give testimony in the Gilboy case?

A. No.

Q. Or the Lejeune case?

A. No.

Q. Did you write reports in either case?

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A. No.

Q. Were both of those cases involving claims by a plaintiff who claimed to have lung cancer as a result of smoking?

A. I believe so.

Q. Did you render an opinion in either of those cases?

A. I discussed it --

MR. SHEFFLER: Objection. Let me -- I think we're getting dangerously close to work product protection here. I would have no objection if you ask him if he rendered an opinion as an expert witness in either testimony or report or deposition. I have no objection to that question.

Q. (By Mr. Scruggs) Then that's the question I'm asking you.

A. Say the question again.

Q. Did you render an opinion in either the Gilboy or Lejeune case as an expert witness?

A. I rendered no written opinion.

Q. Did you render an oral opinion?

MR. SHEFFLER: Objection, unless -- you're restricting your question again in the role not as a consultant. He may not understand this, but as you understand,

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doctors may serve a function as a consultant or as a witness. And if you're asking has he ever testified in a case with respect to any opinion, I have no objection to that question.

Q. (By Mr. Scruggs) Doctor, have you ever rendered an opinion in the Anderson Smith or Wilks case that we're here about today, the Gilboy case or Lejeune case, that tobacco smoke contributed to the inducement of lung cancer?

A. I don't understand your question. Try it again.

Q. Have you ever rendered an opinion in any case, which would include Lejeune, Gilboy and the incident case here, the Anderson Smith case, that tobacco smoke did not contribute to the inducement of lung cancer?

A. You've got about three things in there. If you can break that down.

MR. SHEFFLER: I object to the question, too. That was a different question than the one you posed before.

THE WITNESS: It really was.

MR. SCRUGGS: Read it back.

(The last-above question was read back by the court reporter.)

A. I don't understand the question.

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Q. By Mr. Scruggs I can't ask it any plainer, Doctor.

A. Why don't you break it down case by case.

Q. Did you ever render an opinion in the Lejeune case that tobacco smoke did not contribute to the cancer that the plaintiff claimed to have?

A. I didn't render any opinion in the Lejeune case.

Q. Same question for the Gilboy case?

A. I have not rendered any opinion in the Gilboy case.

Q. Did you ever tell Mr. Sheffler in either of those cases that tobacco was not contributory to the inducement of lung cancer?

MR. SHEFFLER: Objection, instruct the witness not to answer on the grounds of work product protection.

MR. SCRUGGS: I think I'm entitled to know if the doctor has ever said --

Q. (By Mr. Scruggs) Let me put it this way: Have you ever told one of these lawyers that tobacco smoke caused or contributed to the lung cancer in any of these plaintiffs?

A. I really can't answer that question, because I think it's a lot broader question. You're asking can I recall anything I ever said under any circumstances --

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Q. No, sir, I'm asking --

A. Wait a minute. Let me answer the question you asked me.

Q. Thank you.

A. In the process of trying to discuss things, you can discuss an awful lot of things and express tentative opinions without coming down with an iron clad opinion on anything, frequently to create a straw figure to attack one way or the other. If you want to ask me what my opinions are at this moment, I'll be happy to try to answer that. But if you're asking me what I have said to him under any circumstances, I've probably said a whole bunch of things to him.

MR. SHEFFLER: You certainly have, Doctor.

A. But does that mean it's an opinion I want to be etched on my tombstone? Not necessarily.

MR. SCRUGGS: Would you read back my last question?

(The last-above question was read back by the court reporter.)

THE WITNESS: Stop right there. Read the first four words.

MR. SHEFFLER: Wait, wait, Doctor.

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There is no question pending. He just asked the reporter to read the last question.

Q. (By Mr. Scruggs) Now, Doctor, could you answer that question for me?

MR. SHEFFLER: Objection, the question has been asked and answered.

Q. (By Mr. Scruggs) You may answer.

A. I don't know what I have told him.

MR. SHEFFLER: That's an answer.

Q. (By Mr. Scruggs) Did you tell Mr. Sheffler in the Gilboy case that the plaintiff in that case did not have cancer as a result of cigarette smoke?

MR. SHEFFLER: Objection, instruct the witness not to answer. **We're not going to get into any consultation that I had with Dr. Reinarz with respect to the Gilboy case at this time. Objection, instruct the witness not to answer under the grounds of work product protection.**

MR. SCRUGGS: Same with respect to the Lejeune case?

MR. SHEFFLER: Same instruction.

Q. (By Mr. Scruggs) Doctor, in your opinion, did cigarette smoking contribute to the cancer of the plaintiff in the Gilboy case?

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MR. SHEFFLER: Objection on two grounds: Number one, to the extent that Dr. Reinartz has any information as a result of his consultation with me in respect to that case, instruct the witness not to answer on grounds of work product protection; and secondly, there is no foundation that this case involved a plaintiff with lung cancer. My objection with respect to work product stands.

MR. BARRETT: Are you instructing him not to answer?

MR. SHEFFLER: Yeah, on the grounds of work product.

MR. SCRUGGS: Same question with respect to the Lejeune case?

MR. SHEFFLER: Same instruction.

Q. (By Mr. Scruggs) All right. Doctor, let's go back to the time you spent working for Mr. Sheffler or consulting for Mr. Sheffler in the Lejeune case. Do you recall how many hours you spent working on the Lejeune case?

MR. SHEFFLER: Dick, that was asked and answered.

Q. (By Mr. Scruggs Do you recall how many hours you

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spent, approximately how many hours?

A. I said I don't remember.

Q. Was it fewer than 50?

MR. SHEFFLER: Objection.

Q. (By Mr. Scruggs) You can answer.

A. I don't know.

Q. Did Mr. Sheffler or his client pay you in that case?

MR. SHEFFLER: Objection, asked and answered.

Q. (By Mr. Scruggs) In the Lejeune case, Doctor?

A. Yes.

Q. Did they pay you in the Gilboy case?

MR. SHEFFLER: Objection, asked and answered.

Q. (By Mr. Scruggs) You may answer, Doctor.

A. I have not billed for that case.

Q. And you have no idea how much you're going to bill them in that case?

A. No, I really don't.

Q. All right. When did you first do work or consult with Mr. Sheffler in connection with a case where the plaintiff alleged an injury from tobacco products?

A. To the best of my recollection, probably sometime around 1989.

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Q. Did Mr. Sheffler -- was it Mr. Sheffler you worked with?
A. No.
Q. Who was the lawyer?
A. The lawyer in that case I believe was from North Carolina, and I don't remember his name.
Q. Do you remember his firm's name?
A. No, that's even worse.
Q. Do you remember his client's name?
A. It was the Lejeune case.
Q. Well, I understand that. Do you recall the client of the lawyer that asked you to consult with him in 1989 in the Lejeune case?
A. No, sir, I don't.
Q. Was it an attorney for a tobacco company?
A. Yes.
Q. Do you recall the name of the tobacco company?
A. No, I don't.
Q. What about in the Gilboy case?
A. No, sir. As a matter of fact, if you hadn't told me until now, I wouldn't know these folks were from American Tobacco.
Q. Did you know Mr. Sheffler represented American Tobacco?
A. No.

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Q. Did you know he represented a tobacco company?
A. Yes, I did.
Q. Did you know that the attorneys that asked you to consult in the Lejeune and Gilboy case also represented tobacco companies?
A. I knew that.
Q. You're saying today you don't recall the name of the tobacco company?
A. No, sir, I don't.

MR. BARRETT: Let me say something for the record here. We do not have a vehicle available to go to your office or have anybody -- my car is gone and my wife is also gone.

THE WITNESS: I'll make a deal with you, if you come by with me when we leave here, I'll give it to you myself.

MR. SHEFFLER: We can discuss that at the end of the deposition.

MR. SCRUGGS: We'll come back to the CV. It may be that we don't have to do the deposition, at least that part of it, later.

Q. (By Mr. Scruggs) Doctor, you said that you had discussed the Wilks case or the Anderson Smith case on approximately five occasions with the attorneys

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for American Tobacco?

A. Yes.

Q. And the first time was around 1990?

A. I believe so.

Q. Who contacted you?

A. Mr. Sheffler.

Q. What did he ask you to do?

A. He asked me to review the medical records.

Q. You agreed to do so?

A. Yes.

Q. What else happened in the first contact, the first conversation you had with Mr. Sheffler?

A. That's pretty well it.

Q. What happened -- what was discussed in the second conversation you had with him?

A. I presume it was having to do with the medical records. I don't really recall the details.

Q. And on each subsequent occasion?

A. Basically review medical records.

Q. Did he have to tell you five times to review the medical records?

MR. SHEFFLER: Objection.

MR. SCRUGGS: I'll withdraw that.

MR. BAILEY: I hope so.

Q. (By Mr. Scruggs) Doctor, have you reviewed the

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medical records of Anderson Smith?

A. Several times.

Q. Other than the medical records, have you read any testimony in the Anderson Smith case?

A. I have not.

Q. Again, Exhibit 1 is everything, every document you have looked at in connection with this case? I just want to be sure of that.

MR. SHEFFLER: Again, I object as asked and answered.

A. I believe that's true.

Q. (By Mr. Scruggs) Has Mr. Sheffler or any of the lawyers for American Tobacco Company told you anything about the case that is not in Exhibit 1?

MR. SHEFFLER: Objection.

A. I don't believe so.

Q. (By Mr. Scruggs) Have they characterized the testimony of any other witness?

A. No. I don't even know who the other witnesses are.

Q. Doctor, from the review of the medical records in the Anderson Smith case, and based on your own training and experience, did you form any opinions as to what conditions Mr. Smith suffered from, if any, at the time of his death?

A. Yes, I did.

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Q. What conditions did he suffer from?
A. At the time of his death?
Q. Yes.
A. Well, he had about four or five major conditions.
Q. Okay.
A. He had a mass lesion in his lung he was being treated for. He had extensive prostatic and bladder disease. He had bilateral hydronephrosis. He had rather extensive bleeding from his urinary tract following his last attempt at biopsy. And he had an unexplained metabolic acidosis. He was mildly anemic. He carried a diagnosis of chronic schizophrenia. And the medical record reflected that he had chronic obstructive pulmonary disease, or COPD.
Q. Any other conditions that you found significant in your review of his medical records?

MR. SHEFFLER: Objection, that's a different question.

MR. SCRUGGS: I didn't say it was the same question.

MR. SHEFFLER: To the extent you're asking for his opinions with respect to the medical records, let me caution the doctor if you wish to review the medical records in

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response to any question, you certainly have the right to do so.

A. There were a number of factors that transpired. For example, it doesn't specifically mention he was receiving radiation. He was receiving glucocorticoids.

Q. (By Mr. Scruggs) Doctor, let me stop you. I'm not asking what treatments he was receiving. I'm asking what conditions he had?

MR. SHEFFLER: No, no, that's not the question you posed. You're asking of any significant events.

MR. SCRUGGS: No, I didn't, I asked for other significant conditions.

A. Well, but the significant condition, the medications were given in response to other things, so they may not have been specifically spelled out. But, I mean, as an example of that is that he was having -- had had rather extensive irrigation of his bladder for some time following the last biopsy. He had the continued bleeding in the urinary tract, and it had been irrigated with rather large amounts of stabilized solution at that time in order to keep the blood clots from obstructing his urinary flow. But I thought that that was sort of a component to

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what I've already said to you. There may be other things in here which I've not specifically spelled out, but I'm not intentionally leaving them out.

Q. (By Mr. Scruggs) All right. Doctor, let me ask you another question. Do you want to look at the records? You certainly may.

A. I want to get to the point where I can.

Q. I beg your pardon?

A. I just want to --

MR. BAILEY: He wants to have them ready.

MR. SHEFFLER: He said he wants to get to the point that's relevant to answer your questions.

Q. (By Mr. Scruggs) Doctor, were any of these conditions, in your opinion, contributory to Mr. Smith's death?

A. I think any of them could have been.

Q. You did not mention a neoplasm. Do you believe Mr. Smith had a neoplasm?

A. Of course he did. He had a mass lesion in his lung, he had a biopsy, bronchoscopic biopsy. That was read out as squamous cell carcinoma, right upper lobe. That's the mass lesion of the lung.

Q. Do you agree from what you read in Mr. Smith's

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reports that he had squamous cell carcinoma in the right upper lobe of his lung?

A. I just said that.

Q. I asked if you agreed to that diagnosis?

A. Yes, I have no reason to argue with that.

Q. Did you agree with the diagnosis of the other conditions that you mentioned?

A. By and large, yes.

MR. SHEFFLER: That's already -- that's an answer.

MR. SCRUGGS: It is an answer.

Q. (By Mr. Scruggs) Let's go to COPD, which is the last condition you mentioned.

A. Uh-huh.

Q. Could Mr. Smith's COPD have contributed to his death?

MR. SHEFFLER: If you mean -- objection to the form of the question.

Q. (By Mr. Scruggs) If I misunderstood you, correct me, but I asked you if any of these conditions contributed to his death, and you said any of them could have.

A. I did.

Q. Which would include COPD?

A. I did.

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Q. All right. Do you have an opinion based upon a reasonable degree of medical probability whether any of these conditions contributed to his death?

A. As I recall the list I gave you, I think that probably none of those directly caused his death and that his death was probably due to some other antecedent complication.

Q. Can you say within a reasonable degree of medical certainty what caused his death?

A. I can only speculate for you.

Q. You can't say within a reasonable degree of medical probability what caused his death?

A. No, sir. I wish I could. I wish we had an autopsy on him.

Q. Can you say within a reasonable degree of medical probability that COPD did not contribute as a cause of his death?

A. That if COPD contributed, it contributed only in a very minor way to his death.

Q. Could you say within a reasonable degree of medical certainty that the mass lesion in his right upper lobe, the squamous cell carcinoma that is, did not contribute to his death?

A. I repeat the answer, that if the mass lesion in the lung contributed to his death, I think it was in a

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very minor way.

Q. Doctor, let me be a little more specific and press a little bit more there.

A. Please.

Q. Can you say within a reasonable degree of medical probability that Mr. Smith's COPD did not contribute to his death?

A. I think I answered that.

Q. You said if it did, it did in a minor way.

MR. SHEFFLER: He said very minor way.

Q. (By Mr. Scruggs) Very minor way.

A. And I'll stay with that.

Q. All right, sir.

A. He certainly did not die of hypoxia or CO2 retention or of respiratory failure. I mean, that was --

Q. Did he have those conditions?

A. Not really.

Q. Was he anemic?

A. Yeah, but he was bleeding from his bladder.

Q. All right, sir. Now, Doctor, do you believe that Mr. Smith's COPD contributed in a very minor way to his death?

MR. SHEFFLER: Objection.

A. I've already said I don't know what extent of

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contribution it made.

Q. (By Mr. Scruggs) I'm not asking that.

A. But if it made any, it was to a minor degree.

Q. You're not answering my question, Doctor.

A. Well, ask the question.

Q. Did Mr. Smith's COPD contribute in any way to his death?

A. I don't know.

MR. UPSHAW: He answered that as clearly as he could. He said if any --

MR. SCRUGGS: He's not saying whether it did or did not.

A. I said I don't know.

Q. (By Mr. Scruggs) You don't know whether his COPD contributed in a minor way to his death?

A. You stated the answer different than I did.

Q. Okay. We're going to be here as long as this takes, now.

A. Well --

Q. Did Mr. Smith's COPD contribute in any way to his death, in your medical opinion?

A. I don't believe it did.

Q. Did Mr. Smith's squamous cell carcinoma contribute in any way to his death, in your medical opinion?

A. I don't believe it did either.

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Q. Did his prostatic and bladder disease contribute to his death?
A. I think the probability there is much higher.
Q. Can you say within a reasonable degree of medical probability that the prostatic and bladder condition caused his death?
A. I don't think you can say causality, but as far as contributing, I think it was. I think it was the major contributing factor to why he died.
Q. Why do you think that?
A. Well, a variety of reasons. One, he had obvious pathology in his prostate and his bladder.
Q. What do you mean pathology?
A. Well, let me try to answer the question -- okay -- because if you interrupt my process of thought, then I can't give you an integrated answer.
Q. Go ahead.
A. He had definite pathology of both the prostate and the bladder, and on several occasions had had surgical intervention to relieve the obstruction that was caused by the pathologic changes.
Q. Okay.
A. Secondly, he was immediately post-operative from attempting biopsy of his bladder and of his prostate. Tissue was obtained but no diagnosis was

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forthcoming from that. Nevertheless, he had rather extensive bleeding from it, to the extent, if I recall, he had to be transfused as a consequence of that. And he had rather copious amounts of bleeding from his urinary tract, with large amounts of fluid, and then he suddenly expired.

Now, the precise cause of his death calls for speculation from me or from anyone else that would review that record. He could have died from many different things. He could have died from gram-negative sepsis. He could have died from pulmonary embolization. He could have died from electrolyte imbalance. He could have died from cardiac arrhythmia that was brought about by electrolyte abnormalities.

And my best guess is that the major problem was occurring in his prostate, in his bladder. He was immediately post-operative, immediately post general anesthetic. He was being irrigated with large amounts of fluid. And I think one of those or all of those contributed to his death.

Q. Were there any other conditions that you mentioned of these five or six major conditions that you believe contributed to his death?

A. I don't want to force -- I don't want to say there

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were any, but as I can recall at this sitting without going through and re-reviewing this thing in exquisite detail, I think I've included the majority of them, if not all of them.

Q. I'm asking you, Doctor, if you thought any of those other conditions contributed to his death. You said COPD did not, you said the squamous cell carcinoma did not.

A. That's correct.

Q. What about the other conditions? You said one did.

A. I don't remember.

MR. SHEFFLER: Objection, unless you tell what the others were. That was a long time ago.

A. I mean, if you'll ask -- ask me the question, I'll be happy to answer.

Q. (By Mr. Scruggs) You said bilateral, what was it, hydronephrosis. Did that contribute to his death?

A. Yeah. Only within the context his kidneys weren't working well.

Q. So it had some contribution in his death?

A. As far as the electrolyte imbalance is concerned.

Q. What about his urinary bleeding, did that contribute to his death?

A. May very well have.

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Q. Did it or did it not, in your opinion?
A. It may have.
Q. Doctor, can you say within a reasonable degree of medical probability that his urinary bleeding contributed to his death?
A. Urinary bleeding of and by itself is not an event that occurs in isolation. He's bleeding because they punched a big hole in his bladder and prostate and took out big hunks of tissue, and the hunks of tissue are lying there raw, and which you're irrigating fluid in which you've got a catheter, which bacteria gain access to the bloodstream. The bleeding activates clotting cascades in attempt to stop it, and the activation of clotting may very well trigger off generalized clotting elsewhere, including in the pelvic veins, and he may very well have had a series of thrombi within the pelvic veins. Prostatic bends. And may very well have embolized to his lung. And the pulmonary embolization, if in fact he had that, could have been a co-contributor of any of those.

Now, you're asking me to give very simplistic answers to highly complex problems, and I can't do that. It's not that simple. It's not like turning on a light or turning off a light. These are all

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interdigitating variables.

Q. Let me ask you this. Can you say within a reasonable degree of medical probability why Mr. Smith died?

MR. SHEFFLER: Objection, asked and answered.

MR. SCRUGGS: That was a long time ago.

Q. (By Mr. Scruggs) Can you?

A. Sure I can. You want me to go through the whole assembly I just gave you?

Q. No, sir, I want you to tell me within a reasonable degree of probability what killed the man, which condition, if not all these conditions together?

MR. SHEFFLER: Objection. He just asked and answered. You're repeating the same question.

MR. SCRUGGS: He told me things that could. I'm asking what did.

A. What do I think happened?

Q. (By Mr. Scruggs) Yes.

A. My opinion of what the most likely cause was?

Q. Yes.

A. I suspect the most reasonable probability would be either that he had a pulmonary embolization from the

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deep pelvic veins secondary to the surgery and bleeding that he was having, or he developed gram-negative septicemia as a result of the manipulation of his urinary tract, or he had an electrolyte imbalance resulting in a cardiac arhytmia and death. And I think each of those has a plausible and reasonable explanation. As to saying which one clearly did it, I can't tell you.

Q. Just so I can understand the medical terms here, the very first condition you said was, what, pulmonary embolism --

A. Yes.

Q. -- from his deep pelvic veins secondary to surgery?

A. Well, from thrombi within the deep pelvic veins.

Q. Second was gram-negative --

A. Vasolary septicemia. Gram-negative rod bacteriemia. Those are terms that are used interchangeably in the vernacular. The replication of organisms in the bloodstream are introduced to the urinary tract as a result of instrumentation. He had lots of reasons to have that.

He had chronically affected urinary tract, he had repeated obstruction, he had inflammation of his bladder, he got clots that blocked off urinary flow and ended up with distension and distortion where

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organisms could gain ready access to the inflamed mucous membranes and operative site.

Q. Did he have an infection?

A. He had a longstanding chronic infection, yes, sir.

Q. And what was the name of that infection?

A. Well, how about prostatitis, cystitis, palonephritis, all of the above, urethritis. You won't have to go far --

Q. In layman's terms, Doctor, are you saying Mr. Smith's urinary problems were the major cause of his death?

A. They were co-contributors, yeah. I think if he hadn't had the urinary tract problems, he wouldn't have had the surgeries, that the full pathology of his urinary tract has not been defined in that they were doing the biopsy of the prostate and his bladder because they thought there was cancer there. And by no means have those been excluded.

Q. Do you believe that he had cancer in his urinary tract?

A. Yeah, I do.

Q. All right. Based on what?

A. On what they describe what they saw there.

Q. So it's your opinion that Mr. Smith had a urinary tract cancer?

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A. Might very well have.
Q. Would it have been a primary cancer or a metastatic cancer from somewhere else?
A. I think it most likely would be a primary tumor.
Q. Are you saying within a reasonable degree of medical probability that Mr. Smith suffered from a urinary tract cancer?

MR. SHEFFLER: Objection.

A. I am saying that the doctors taking care of him describe papillary changes in his prostate and of his bladder which they thought were consistent with cancer and for which they did biopsies.
Q. (By Mr. Scruggs) All right, sir. What were the results of the biopsies?
A. The results of the biopsies were indeterminate.
Q. So can you say as you sit here today --
A. You asked me what I believed. I said I believe he had one.
Q. I'm asking you another question now, Doctor. Can you say within a reasonable degree of medical probability that Mr. Smith had a urinary cancer?
A. I don't know that.
Q. Okay. You are saying that his urinary tract problems were a major contributing factor in his death?

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A. Yes, I am.
Q. Besides his urinary tract problems, what other problems were a major contributing factor to his death?
A. I think those were the principal proximate contributing factors to his death.
Q. Do urinary tract problems, Doctor, fall under the discipline of medicine known as urology?
MR. SHEFFLER: Objection. Objection to the question.
A. A component of it.
Q. (By Mr. Scruggs) Is there a medical speciality called urology?
A. Sure there is.
Q. And do those physicians who are urologists traditionally treat urinary tract problems like Mr. Smith had?
A. Not exclusively.
Q. I didn't say that. I said do they traditionally treat them?
A. Yes, of course.
Q. Does that fall under the purview of their speciality?
A. Yes.
Q. Are you a urologist?

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A. No.
Q. Have you ever taken the boards in urology?
A. No.
Q. Do you have a special expertise in urology, other than that possessed by any other board certified internal medicine physicians?
MR. SHEFFLER: Objection to the question.
A. Probably.
Q. (By Mr. Scruggs) Do you? And why do you say you have a special expertise in urology?
A. Well, I don't so in urology, but as far as infections of urinary tract, it's a major component of infectious disease.
Q. Doctor, was it an infection in Mr. Smith's urinary tract that caused his death?
MR. SHEFFLER: Objection, asked and answered at least four times.
Q. (By Mr. Scruggs) Was it an infection that did it or was it --
A. I said it is a possibility.
Q. Is it your opinion within a reasonable degree of medical probability that an infection in Mr. Smith's urinary tract caused his death?
MR. SHEFFLER: Objection, asked and

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answered repeatedly.

A. I said that there were -- I did not know what his exact cause of death was, there were multiple possibilities. But the second one on the list I believe I gave you was an infection arising from the urinary tract of gram-negative bacteriemia.

MR. SCRUGGS: Read the last question back, please.

(The last-above question was read back by the court reporter.)

MR. SHEFFLER: Would you read the answer, please?

(The last-above answer was read back by the court reporter.)

MR. SCRUGGS: Read my question back again. And, Doctor, is that -- are you going to continue with that answer?

Mr. Sheffler, is that what you're going to instruct him to do? He can answer "yes," "no," or "I don't know."

MR. SHEFFLER: You ask the question again and he'll give the same answer, I imagine.

THE WITNESS: Can we come off the record a second?

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MR. SCRUGGS: Fine with me.

MR. SHEFFLER: You know what bacteriemia is?

MR. SCRUGGS: No, I don't have any idea what it is.

MR. SHEFFLER: Why don't you ask him.

MR. SCRUGGS: I'm taking the deposition now, Bruce.

THE WITNESS: Are we going off the record?

MR. SCRUGGS: I'm asking a question that you haven't given the answer for.

MR. BAILEY: Certainly he did. You don't understand the answer.

MR. SCRUGGS: No, no, no, he has not answered my question. It's a yes or no question. Is it your opinion --

MR. SHEFFLER: You don't have to answer any question "yes" or "no" if you feel you would otherwise like to answer it with an explanation.

THE WITNESS: What am I supposed to do at this point?

MR. SHEFFLER: You are to --

MR. BAILEY: There is no question on

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the floor.

MR. SHEFFLER: You're supposed to wait until Mr. Scruggs asks you the question and respond to the best of your ability to it.

THE WITNESS: I have been.

MR. SHEFFLER: Okay. Ask your question.

MR. SCRUGGS: Read the question back.

THE WITNESS: Are we off?

MR. SCRUGGS: No, we're on.

THE WITNESS: What I would like to do is show him what's wrong with the question.

(The last-above question was read back by the court reporter.)

MR. SHEFFLER: You have -- I mean --

MR. UPSHAW: Let him answer it again.

MR. SHEFFLER: I instruct you, Dr. Reinarz, to answer Mr. Scruggs' questions to the best of your ability, to the extent they're answerable.

A. I don't believe an infection confined to his urinary tract caused his death.

Q. (By Mr. Scruggs) Doctor, did it -- I'm sorry.

A. However, an infection in the urinary tract has its

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effects not just in the urinary tract, but in the surrounding areas as well in that the products of the infection are drained into the lymphatics, they are drained in the venous structures coming from there, and they are very likely to produce a pelvic cellulitis, clots within pelvic veins, what have you.

That's a lot more detailed than you've asked, and I'm also speculating for you that if a person with a chronic inflammation that has relatively extensive surgery and then has it bleeding and the area gets obstructed, bacteria have ready access to the bloodstream. That's what we call **bacteriemia**, when bacteria get in the bloodstream and circulate and produce a syndrome of gram-negative sepsis. Is it possible? Yeah.

Q. Doctor, that was not my question. Let me -- I'm going to ask it one more time for you.

A. Ask it.

Q. I'm going to modify it somewhat. Is it your opinion beyond a -- or to a reasonable degree of medical probability that an **infection** produced or caused or contributed to Mr. Smith's death?

MR. SHEFFLER: Objection, asked and answered, and it's compound.

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Q. (By Mr. Scruggs) Confine it to the urinary tract, Doctor. I'm asking you if an infection --

A. The medical record simply does not allow that question to be answered with a high probability of certainty. Is it a distinct possibility, yes.

Q. Let me put it to you a different way. Is it more likely than not, in your opinion, that an infection contributed to Mr. Smith's death?

MR. SHEFFLER: Objection.

A. I don't know the answer to that question.

MR. SCRUGGS: Thank you. Let's take a little break now.

(Brief recess.)

Q. (By Mr. Scruggs) Doctor, correct me if I'm wrong, but in your testimony earlier today, you ruled out COPD as a contributing factor of Mr. Smith's death; is that correct?

A. Sure, yes.

Q. Did Mr. Smith have COPD?

MR. SHEFFLER: Objection, asked and answered.

A. The medical records said that he did.

Q. (By Mr. Scruggs) Do you agree with that diagnosis from what you've seen in the medical records?

A. There is a little hard data that says that he had

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chronic obstructive pulmonary disease. What is not determined is what is chronic, how long is chronic, what does it take to be chronic. There are phases in his medical illness when he had an obstructive component that were described by the different doctors that took care of him. He had some pulmonary function tests which were not terribly helpful and raised the question as to how much was problems with his lung and how much of it was problems with his effort or his understanding of the test that was to be done. The objective data that say that he had significant obstructive lung disease is equivocal.

Q. Did you review any pulmonary function test results of Mr. Smith?

A. Yeah.

Q. Would you show me the ones that you reviewed in Exhibit 1.

A. Whatever is in that record.

THE WITNESS: If you'll find the pulmonary function tests, we reviewed them.

MR. BARRETT: I can't even spell them.

MR. SHEFFLER: Bruce, do you know where they are offhand? If you don't

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mind --

MR. SCRUGGS: I don't mind.

MR. SHEFFLER: -- we can take it off of my copy and it will be easier.

A. Here is one of 12-27-85. Here is one of 1-3-86.

Q. (By Mr. Scruggs) 12-27-85 and 1-3-86?

A. Uh-huh. Yes. 12-27-85 and 1-3-86.

Q. Any others?

A. There may have been.

MR. SCRUGGS: Do you mind if we mark these?

MR. SHEFFLER: I do.

MR. SCRUGGS: We can substitute a copy if you want to.

MR. SHEFFLER: That's fine. Let's go off the record.

(Discussion off the record.)

THE WITNESS: Actually, they have interpretations on them, too, that are not on your record.

MR. SCRUGGS: Let's mark this Exhibit 4 and this Exhibit 5.

(Reinarz Deposition Exhibit Nos. 4 and 5 marked for identification.)

Q. (By Mr. Scruggs) Doctor, first of all, what is

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chronic obstructive pulmonary disease?

A. Oh, boy. It's sort of a wastebasket term.

Q. And what goes into the wastebasket?

A. Well, you're talking in terms of chronic obstructive lung disease, you're really talking about a condition which is present over a number of months and which is associated with impaired ventilation, usually with exhalation or moving of air out of the lungs, if you will. It may be caused by loss of elasticity of the lung or by swelling or inflammation or secretions within airways.

Reasonably, he probably has some element of obstruction in his lungs right now. He's got an upper respiratory infection, he's got swelling of his bronchi and smaller airways.

MR. UPSHAW: Let the record show he's pointing to me.

A. The question then is when does this become physiologically significant in that the loss of elasticity is something which occurs as a consequence of aging. It's largely dictated by what problems you've had in your lungs, what your genes say and how old you become.

Q. (By Mr. Scruggs) Doctor, do you include within the definition of COPD pulmonary emphysema?

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A. Emphysema is really a pathologic diagnosis in which you have hyperinflated airways and destruction of septum within the lung. And the diagnosis of emphysema is difficult to make without a biopsy and without autopsy.

It is true that chronic obstructive lung disease and emphysema commonly co-exist in that they sort of get crudely lumped together in a diagnosis. The textbooks try to make it a lot clearer and try to take this, a morphous mess, and put a few terms together that you can use to communicate. But the individual patient that they are -- there may be wide limits to what you're talking about.

Q. Doctor, is it your testimony that you cannot make a diagnosis of emphysema based on clinical signs and symptoms, but you must have a biopsy or pathology available to make the diagnosis?

A. Well, you can make -- anyone can make any kind of diagnosis based on whatever criteria they want. Whether that diagnosis is universally accepted by experts in the field or anyone dealing with it is another question.

Q. Doctor, would you refuse to make a diagnosis of emphysema without pathology?.

A. I think I would be reluctant to say anyone had pure

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emphysema without a biopsy, yeah.

Q. Okay. Doctor --

A. Because existing in its pure form is relatively uncommon. Now, you say you have chronic lung disease with emphysematous changes, that's a different category. And one is more descriptive as opposed to central lobular emphysema or what have you. Those are pathologic diagnosis.

Q. Doctor, would you diagnose a patient with chronic lung disease with emphysematous changes without pathology?

A. I have, yes.

Q. All right. What are the signs and symptoms of chronic lung disease with emphysematous changes?

A. Well, first of all, they are very prolonged. And it has to do with the symptomatology the patient has.

Q. I'm asking what that is.

A. Well, I'm getting there. **The symptomatology is usually shortness of breath, and that** -- shortness of breath with exertion, and that shortness of breath with exertion will usually precede or antedate in any other findings.

In it's more severe forms, the shortness of breath may be present at rest, may be associated with positional changes, may be associated with

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difficulty in moving air; that is, a person who has much in the way of obstructive disease will be breathing against pursed lips so as to raise their airway pressure. But you would have to make this a composite thing, history, physical findings, radiographic changes, pulmonary function tests and blood gases. And further you would need to do this over a prolonged interval.

The other variable you want to talk about is how much of it is reversible. And reversibility has to do with how much component bronciospasm plays in that. An asthmatic will have all of the features of chronic obstructive lung disease. And long-term chronic asthmatics have chronic obstructive lung disease. And the thing which usually separates the asthmatic is the reversibility. Although the asthmatic with prolonged asthma will lose their reversible component.

Q. Doctor, if I understand you, you've listed as the signs and symptoms, shortness of breath, a history --

A. A history of shortness of breath, usually progressive, and usually shortness of breath with exertion in which you can elicit a history of progressive loss of endurance in exercise tolerance.

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Q. Radiographic changes you --
A. That's the third thing I stated.
Q. Okay. I'm a little confused. Shortness of breath, is that separate, a separate symptom from history, or is it a history of shortness of breath?
A. History are those features that the patient complains of that cause him difficulty, of which shortness of breath would be more dominant.
Q. What other history would you look for?
A. Shortness of breath, shortness of breath with exertion, orthopnea, labored breathing, wheezing. And again, it depends on when in this you're talking about. There is probably no one in this room who doesn't have some chronic lung disease, in that there is --
Q. Doctor, I'm trying to determine your criteria for diagnosing COPD.
A. Again, I can probably make that diagnosis in you in its milder forms.
Q. All right, Doctor. I disagree with that. But -- no, I take that back. You probably could. But let's go into this a little further. The side of history. What radiographic changes would you look for?
A. Depends on the stages you're looking at. Are you

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talking about early disease; talking end stage disease? Now, then, you're talking about in terms of tremendously hyperexpanded chest, talking widen AP diameter, talking widening of inner spaces of depression and flattening of the diaphragms, perhaps peridoxic movement of the diaphragm, minimal excursion of the chest in inspiratory and expiratory components. However, probably your single most valuable one is the physical exam.

Q. What do you look for in a physical exam?

A. What can't you look for? Expansion of the chest, widening of the interspaces, depression of the diaphragm, wheezing, especially during expiration and prolongation of the expiratory phase before expiration. If they're having -- if they are having ventilation profuse in mismatching, you look for clubbing, look for cyanosis, look for the use of accessory muscles of expiration.

Q. Okay. Pulmonary function. What do you look for?

A. The hallmark of lung obstruction disease is obstruction and its diminution in air flow.

Q. What value would you look for?

A. There is no single one you look for. Probably the most predictive of you is your is FEV .25 to .75.

Q. Should that be increased or decreased?

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A. Should be markedly decreased if you've got significant obstructive lung disease.
Q. What did you call that?
A. FEV .25 to FEV .75.
Q. Is that the same as FEF .25 to .75?
A. Yes.
Q. What about FEV 1?
A. It's a cruder form of it. Same thing.
Q. Look for that to be reduced?
A. Sure.
Q. What other values would you look for in a pulmonary function study for COPD?
A. Depends on the sophistication of your pulmonary function study. If you've got really sophisticated pulmonary function studies, you'd have stated overall total lung volume ought to be increased.
Q. What other values are important in the diagnosis of COPD?
A. Well, again, in the ones that you're referring to, the tests here, these are mostly effort dependent pulmonary function -- wait, I'll come back to that.
Q. We'll be here a long time, Doctor. You're not answering my question. I'm asking what other values do you look for other than FEV 25.75 --
A. I already told you, the forced expiratory value, one

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second, the three second, your flow rates, your total lung volume, your closing pressures, if you can measure that. But none of these of and by themselves have to be taken in the context of the entire picture.

Q. I understand.

A. And you also have to be -- you have to understand the reason for which the test was ordered. Are you looking for early disease? Are you looking to pick up a group out of a population? Are you looking to follow progress of disease? Are you assessing whether they may be an operative risk for a lung dissection? And there are different reasons why you do different tests.

Q. Doctor, did you look at the pulmonary function tests of Anderson Smith?

A. I did.

Q. What did you see in his pulmonary function studies? Are they represented by Exhibits 4 and 5?

A. The two I've seen, yeah.

Q. Do you know of any others that you've seen other than 4 and 5?

A. I think these are probably most of them, or all of them.

Q. What is it about those pulmonary function studies

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that would lead you to believe that Mr. Smith did not have COPD?

MR. SHEFFLER: Objection to the question.

MR. SCRUGGS: We will strike that.

A. I really haven't thought of it in that context.

Q. (By Mr. Scruggs) You believe Mr. Smith did have COPD?

MR. SHEFFLER: Objection, asked and answered.

MR. SCRUGGS: I don't believe what you said.

MR. SHEFFLER: Okay.

A. I believe he had a component of chronic lung disease, and that --

Q. (By Mr. Scruggs) All right, Doctor --

A. And these tests are very difficult to interpret because of two problems that are raised on the record, itself, and because of the results of the result. One, and I've tried to tell you this, is that they are effort dependent, which means that you have to hear what's being asked; and, second, you have to understand what's being asked; and, third, you've got to want to do what's being asked, in that the disclaimer on the first one was that the patient

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has hearing difficulty.

For example, on his total lung capacity, or vital capacity, forced expiratory flow, if you will, that the predicted value is 4.8 liters and he actually was able to expire 2.7 liters, which is less than half of what his predicted amount would be, that is counter to what you would expect in anyone with obstructive lung disease.

Q. Which value was that?

A. The very first one.

Q. Which is?

A. Forced vital capacity. The great majority of patients with obstructive lung disease should have high vital capacities, it just takes them a long time to get it out there. And their problem is one of air flow, not total volume. And you would have to interpret off of that that that would represent a failure to understand what you're trying to accomplish.

Q. Doctor, what indicates to you about Exhibit 4, or why would you believe that Mr. Smith did not make an effort to perform that test properly --

MR. SHEFFLER: Objection, he just answered that question.

Q. (By Mr. Scruggs) -- other than the fact that his

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forced vital capacity was less than 50 percent of predicted?

A. He did it sluggishly and slowly. One other thing --

Q. Woah, woah. Why do you say he did it sluggishly and slowly --

MR. SHEFFLER: Other than what you've already testified.

Q. (By Mr. Scruggs) -- other than the fact that the volume is half what's predicted?

MR. SHEFFLER: From Exhibit 4 alone we're talking about, right?

MR. SCRUGGS: From anything.

Q. (By Mr. Scruggs) From anything you've looked at, Doctor, why do you think Mr. Smith did not perform with satisfactory effort, other than the fact that his forced vital capacity was less than 50 percent of predicted?

A. Well, if I were interpreting this, and this was presented to me, and they said, why are we doing a pulmonary function test, because we thought he had chronic lung disease, it would be inconsistent to having a lowered volume in that the -- in that I would have to raise the question.

I'm not trying to put any motives in the thing, but I said in order to interpret the thing, you've

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got to -- you've got to hear what they want, you've got to understand what they want and you've got to be able to do what they want. Now, I suspect that's sort of hard at times.

Q. Are you saying that because Mr. Smith was hard of hearing, that he did not make a satisfactory effort to perform that test?

A. That calls for speculation. I think the person who interpreted the test, or the person who did the test, wrote on there that the patient is hard of hearing.

Q. All right, sir.

A. And I think that they may have made that comment because they may not have understood -- he may not have understood what it was they were trying to accomplish.

Q. All right. The fact that he was hard of hearing and the fact his forced vital capacity was reduced to less than 50 percent of predicted is what leads you to believe that Mr. Smith did not make a satisfactory effort to perform the test; is that correct?

MR. SHEFFLER: Objection. If by your question you are limiting his basis for his opinion to only those two factors, I object.

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Q. (By Mr. Scruggs) I'm asking you, what are the factors, from the records you've looked at, Doctor -- let me finish my question, now. What are the factors from the records you looked at that lead you to believe Mr. Smith did not make a satisfactory effort to perform his pulmonary function study as represented by Exhibit 4?

MR. SHEFFLER: Before you answer, I would like to get the records back from Mr. Barrett and let him look at those, unless you want me to show him my records.

MR. SCRUGGS: No, that's fine, go ahead.

MR. BARRETT: Would it be easier? If you could find them quicker, wouldn't it be easier to do that?

MR. SHEFFLER: Well, I mean --

MR. BARRETT: It doesn't matter.

MR. SHEFFLER: Whatever you want to look at.

A. The answer to the question: No single thing. The only thing you can interpret from this is that you may want to take other things into consideration than that these numbers as being absolutely ordained divine figures. And that the -- and that the

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medical record it reflects that the tumor board, the doctors taking care of him, didn't think he was putting forth a very good effort either and wanted to repeat a pulmonary function test on him.

Q. (By Mr. Scruggs) They did another pulmonary function test on him, didn't they?

A. I'm still answering your first question. If you take the fact that the test is not consistent and the man is hard of hearing and the people taking care of him didn't think they were reliable, those form my basis for saying that I don't put a lot of weight on what those show.

Q. Where in the records did the tumor board say he didn't make a satisfactory effort in his pulmonary function test? Give me a Bates stamp number there.

A. I'm having a hard time finding the precise area that said that they thought there was question of effort, but the medical record alludes to it in two or three different areas.

Q. Doctor, isn't one of the ways to determine whether a patient is putting forth a good effort on a pulmonary function study is to compare the results of one study with the results of another study taken at a different time?

A. Yes, but probably better done repeatedly in the same

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setting, because it's difficult -- I'm not in any way suggesting he's trying to falsify the test, but the question is how much of it he understood. And what he -- since it does require a coordinated effort to do this, that in a man that doesn't feel good and that is sedated, it's hard to do.

Q. Doctor, what is it -- was Mr. Smith sedated when he performed the pulmonary function study represented by Exhibit 4?

A. Probably not.

Q. Okay. So he was not sedated?

A. He was sedated -- as I recall, he was taking Halcion, was he not?

Q. Perhaps at some time. Is it your testimony from your review of the records that he was taking Halcion when he performed the pulmonary function study represented by Exhibit 4? Doctor, what I'm trying to find out are all the reasons you think that Mr. Smith did not make a satisfactory effort in performing the test represented by Exhibit 4?

A. I don't know why he didn't make a satisfactory effort. But there are a multiplicity of reasons why a person might not make a satisfactory effort.

Q. Doctor, there is no question of that. I'm asking for your opinion as to why you believe that

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Mr. Smith did not -- are you saying that Mr. Smith did not make a satisfactory effort in performing Exhibit 4?

A. That was my interpretation off of the --

Q. Okay. So it's your interpretation?

A. And it was the doctors' impression also that if they cleared up the reversible component with Prednisone and with Theophylline and it re-educated him, the pulmonary function tests would improve.

Q. Doctor, where does the doctor say that this pulmonary function test represented by Exhibit 4, where in the medical records does it say --

A. Explicitly it does not.

Q. Where implicitly does it say that?

A. The pulmonary doctor did the bronchoscopy.

Q. When?

A. 1-15-86.

Q. Which was more than two weeks later?

A. But the same problem would apply to any and all of them.

Q. Pulmonary doctor that did the bronchoscopy --

A. Mid-January. Recommendation, "FEV 1 can be improved and pulmonary function test repeated. He would be a candidate for a right upper lobectomy with a resection into the bronchis. Pulmonary function

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probably is a reflection of cooperation" that word.

MR. SHEFFLER: Your guess is as mine.

A. Anyway, it's at that point they are suggestin decreasing the steroid dose as well. But the rational --

MR. SHEFFLER: You've answered th question.

Q. (By Mr. Scruggs) The steroid dose being Prednison is that correct?

A. Yes.

Q. Would Prednisone increase or decrease his ability to perform a pulmonary function study?

MR. SHEFFLER: If you know.

A. It depends on when you're talking about.

Q. (By Mr. Scruggs) Doctor, if Mr. Smith were taking Prednisone when he performed Exhibit 4, would you expect his performance to be better or worse than were he not on Prednisone?

A. Depends on why the performance was bad.

Q. Doctor, Prednisone taken alone. Come on, don't be too difficult for me.

A. I'm not being difficult at all.

Q. Doctor, would Prednisone increase or

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ability the perform a pulmonary function study?

MR. SHEFFLER: In Anderson Smith or anyone? I object.

Q. (By Mr. Scruggs) In anyone. What would Prednisone have --

MR. SHEFFLER: If the patient is cooperating or not cooperating? I object.

MR. SCRUGGS: Any patient.

A. You can't answer that question.

Q. (By Mr. Scruggs) Let's assume full patient cooperation. All other things being equal, would Prednisone increase or decrease the patient's abilities to perform a pulmonary function study?

A. I don't know.

Q. So you don't know whether Mr. Smith being on Prednisone had any affect on his pulmonary function study?

MR. SHEFFLER: Objection, that's not what he said.

A. That's not the question you asked me.

Q. (By Mr. Scruggs) Is it your opinion Mr. Smith's being on Prednisone had an effect on his performance on Exhibit 4?

A. I don't think I can answer the question.

Q. Okay. So you don't -- you do not know whether

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Prednisone affected Mr. Smith's performance on Exhibit 4?

A. Mr. Scruggs, you're asking two different questions that don't parallel.

Q. I'm asking one question, Doctor. Do you know whether or not Prednisone affected Mr. Smith's performance on Exhibit 4? You don't know whether it did or not?

A. No. And nobody else does either.

Q. Would Prednisone tend to make a patient, all other factors being equal, perform better or worse?

A. You can't answer that question.

MR. SHEFFLER: Objection.

Q. (By Mr. Scruggs) You can't answer that question?

MR. SHEFFLER: Objection, unless --

A. You can't answer that question.

Q. (By Mr. Scruggs) I can, but you can't.

A. No, you can't either.

MR. SHEFFLER: Please, give me a chance to object where it's necessary to do so. Object to the question unless you specify whether the patient you're talking about is one who has the pulmonary disease or not; two, is cooperating or not, which is not the question you asked. Therefore,

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objection.

THE WITNESS: Further objection. It has a pulmonary disease that responds to steroids.

MR. SHEFFLER: That's the third one.

Q. (By Mr. Scruggs) Doctor, did Mr. Smith have a pulmonary disease that responded to steroids?

A. Jesus.

MR. SHEFFLER: I object.

A. I can't answer the question.

Q. (By Mr. Scruggs) Okay. Do you have an opinion as to whether Mr. Smith's performance on the pulmonary function study represented by Exhibit 4 was affected by his taking of Prednisone?

MR. SHEFFLER: Objection, that's the third time you asked the question.

MR. SCRUGGS: No, it's not. It's not.

Q. (By Mr. Scruggs) Do you have an opinion as to whether or not Mr. Smith's performance on Exhibit 4 was affected by his taking of Prednisone?

A. At this time, I don't have an opinion. I'll be happy to study and give you an opinion later.

Q. Now, what leads you to believe, other than the fact that he was hard of hearing, the fact that his

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forced vital capacity was less than 50 percent of predicted, and the surgical note of the bronchotopist that you mentioned earlier, what leads you to believe that Mr. Smith did not make a satisfactory effort in performing Exhibit 4?

MR. SHEFFLER: Are you intentionally leaving out his diagnosis of chronic schizophrenia?

MR. SCRUGGS: No.

Q. (By Mr. Scruggs) I'm asking what leads you to believe his performance was not satisfactory?

A. I think you have to take the entire composite. The doctors taking care of him thought he was not putting forth the max effort and raised the question of why he wasn't doing it.

Q. Where do you see the doctors raising the question he was not putting forth --

A. I just read it to you on the 16th of --

MR. SHEFFLER: It was the progress notes.

A. It was a progress note, yes.

Q. (By Mr. Scruggs) Doctor, is it not a fact that the technician or whomever performed the pulmonary function study represented by Exhibit 4 noted that the patient's cooperation was fair?

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A. Yeah.
Q. All right. And did he not perform another, or someone else perform another pulmonary function study on Mr. Smith approximately a week later, on January 3rd, 1986, wherein his cooperation was noted good?
A. I understand that.
Q. Is that correct?
A. That's what they said.
Q. The technician said his cooperation was good?
A. Yes.
Q. Is there any note on there, Doctor, that would lead you to believe that his cooperation was anything other than good?

MR. SHEFFLER: On Exhibit 5 written by the technician?

MR. SCRUGGS: Yes.

MR. SHEFFLER: There is no writing on Exhibit 5.

Q. (By Mr. Scruggs) Right. So the answer is nothing; is that correct?
A. I believe it is.
Q. All right. Doctor, was his forced vital capacity greater or less than 50 percent on Exhibit 5?
A. It was 47 percent.

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Q. All right. And on Exhibit 4 it was 43 percent, wasn't it?
A. Yes.
Q. Doctor, would you agree that those are fairly reproducible results?
MR. SHEFFLER: Objection. What's "fairly" mean?
A. I'll say the results of the two were very close.
Q. (By Mr. Scruggs) Thank you. Doctor, on Exhibit 4, what was Mr. Smith's forced vital capacity -- I'm sorry, forced expiratory volume in one second, FEV 1?
A. It was 2.33 liters.
Q. And what percent of predicted was that, Doctor?
A. That was 34 percent of predicted.
Q. Doctor, is a forced expiratory volume in one second of 34 percent of predicted --
A. I'm sorry, I read that to you wrong. His FEV 1 in one second was 1. liter -- was 1.03.
Q. All right. And what predicted was that, Doctor?
A. Well, that was 31 percent of predicted, but --
MR. SHEFFLER: That's all the question he asked.
MR. SCRUGGS: If he needs an explanation, go ahead.

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MR. SHEFFLER: He wants to ask you to read the numbers. You read the numbers.

MR. SCRUGGS: I'm going to do more than that.

MR. SHEFFLER: He'll ask the question and you'll have the chance to respond.

Q. (By Mr. Scruggs) Does that not indicate air flow obstruction, Doctor? An FEV 1 of 30 percent predicted would indicate an air flow obstruction, would it not?

A. It could represent it. It could also represent the fact he isn't pushing very hard.

Q. What's his FEV 1 on Exhibit 5 in terms of percent of predicted?

A. It's 1.22.

MR. SHEFFLER: Percent?

A. Thirty-six percent.

Q. (By Mr. Scruggs) Is that also reproducible from Exhibit 4?

MR. SHEFFLER: Objection, Exhibit 5 reproducible from Exhibit 4? Object to the question.

A. I'm sorry, I didn't hear the question.

Q. (By Mr. Scruggs) Is his effort in Exhibit 5 similar to his effort in Exhibit 4?

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A. Right.
Q. And the values of his FEV 1 in Exhibit 4 and 5 were very close, were they not?
A. Yes.
Q. Doctor, in Exhibit 5, his cooperation and effort were termed to be good, were they not, by the technician who took the test?
A. Whoever wrote that, yes.
MR. SHEFFLER: Asked and answered.
Q. (By Mr. Scruggs) Now, Doctor, would you say that an FEV 1 would indicate a severe air flow obstruction -- would be consistent with a severe air flow obstruction?
MR. SHEFFLER: Objection, asked and answered.
Q. (By Mr. Scruggs) FEV of 31 percent would be consistent with a severe air flow obstruction?
MR. SHEFFLER: Same objection.
A. If the test was properly performed.
(Discussion off th record.)
Q. (By Mr. Scruggs) Doctor, what did you just say to Mr. Sheffler, other than some personal criticism of me, probably?
MR. SHEFFLER: Let the record reflect that Dr. Reinarz was expressing frustration

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with his inability to --

MR. BARRETT: Let Dr. Reinarz speak for himself.

THE WITNESS: I said I would like to teach you some pulmonary function testing.

MR. SCRUGGS: I'm going to give you a chance, Doctor.

MR. SHEFFLER: No, not now.

Q. (By Mr. Scruggs) Doctor, is the fact that Mr. Smith's forced vital capacity, or forced expiratory volume in one second being 30 percent of predicted, or approximately 30 percent of predicted, in any way a result of his force vital capacity being below 50 percent?

A. I don't understand your question.

Q. Would you expect a person whose forced vital capacity was reduced to also have a reduction in his FEV 1?

MR. SHEFFLER: Objection, you asked him that before.

A. Depends upon the reason.

Q. (By Mr. Scruggs) Okay. Doctor --

A. It really does. For example --

Q. What is the significance of what is known as the FEV 1 percent, or FEV 1 over FEC ratio?

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A. It's a ratio of air flow. It's a rate.
Q. Okay, Doctor. And what's the significance of that in analyzing the pulmonary function study for the presence of obstruction?
A. All of that is predicated upon a valid test.
Q. You're not going to answer my question, are you, Doctor? What is the significance, assuming a valid test, of the ratio?
A. Assuming a valid test?
Q. Assuming a valid test of FEV 1 over FEC?
A. It's a a crude measure of obstruction.
Q. Okay. Would you expect that ratio to be above one or below one in an obstructive case?
MR. SHEFFLER: With full cooperation?
A. There is no possible way it could be above one.
Q. (By Mr. Scruggs) No possible way?
A. Huh-uh.
Q. What would you expect to see on an obstructive case on FEV 1/FEC ratio?
A. The reason it can't be more than one is you can't blow out more than one second than you would blow out total.
Q. Doctor, let me ask you, what is the significance of a reduced FEV 1 over FEC ratio?
A. That would reflect airway obstruction.

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Q. Doctor, would you compute for me the ratio of Mr. Smith on each of his two tests represented by Exhibit 4, the FEV 1 percent on each one? It's not given on the test, that I can read it. In other words, would you divide into his FEV --

A. Sure. FEV 1 versus total --

MR. SHEFFLER: Do you have a calculator?

MR. BARRETT: I do.

MR. SHEFFLER: Have you done the figures, why don't you just assume for me, Doctor, that that shows X, Y, Z, and let's go on, rather than doing arithmetic games here.

A. Do you have the figures?

Q. (By Mr. Scruggs) All right. Doctor, tell me what the FEV 1 was on Exhibit 4 in actual volume?

A. The FEV 1 was 1.03.

Q. And what was the FEC?

A. Was 2.07.

Q. I'm sorry?

A. Two period zero seven. It's approximately 50 percent.

Q. Okay. That's what I would guess.

A. Good.

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Q. Would that indicate an air flow obstruction, Doctor, all other factors being equal?
A. A small air flow obstruction.
Q. A small air flow obstruction, 50 percent of predicted?
A. Yeah.
Q. All right. And what is the FEV 1 on Exhibit 5, 1.22?
A. 1.22 and 2.27.
Q. And again, that's about 53, 54 percent?
A. Huh-uh.
Q. That would also indicate an air flow obstruction?
A. Uh-huh.
Q. Is there anything on Exhibit 4 or Exhibit 5, in your opinion, that indicates that Mr. Smith did not have an obstructive process on air flow obstruction?

MR. SHEFFLER: Other than what you've already testified to?

MR. SCRUGGS: No, period.

A. No.
Q. (By Mr. Scruggs) So you would agree that on the basis of Exhibit 4 and Exhibit 5, looking at no other factors, Mr. Smith had an air flow obstruction?

MR. SHEFFLER: Assuming full

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cooperation.

MR. SCRUGGS: Assuming satisfactory cooperation.

A. Although the major abnormality on the test is that there is a restriction.

Q. (By Mr. Scruggs) There is restriction?

A. Yeah.

Q. And --

A. And restrictive component is significantly more than the obstructive component in both tests, predicated upon a normally performed test by a motivated individual who understands what you're doing.

Q. Did you ever see a pulmonary function test of Mr. Smith where his residual volume is given?

A. I don't recall. If it's on here.

Q. Would you look and see?

A. Residual volume here was 4.56. I take it that was a calculated result in which it was expanded.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, at the time the pulmonary function studies were performed on Mr. Smith, that is late '85 and early '86, did he have a mass present in his right upper lobe?

A. Yes, he did.

MR. SHEFFLER: Excuse me, can we go

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off the record for a second?

Discussion off the record.

Q. (By Mr. Scruggs) Doctor, can you rule out respiratory problems as a contributing factor in Mr. Smith's death?

MR. SHEFFLER: Objection, asked and answered.

A. It sort of depends on what you mean by respiratory problems. He's had a whole bunch of them.

Q. (By Mr. Scruggs) Okay. What do you mean -- did Mr. Smith have respiratory problems?

MR. SHEFFLER: At what time?

Q. (By Mr. Scruggs) At the time of his death, Doctor.

MR. SHEFFLER: Objection, he found --

MR. SCRUGGS: We're going to be here two days now.

A. But he wasn't breathing when he was dead, that's true.

Q. (By Mr. Scruggs) That's after he died, Doctor. I'm talking about at the time of his death, immediately preceding the time of his death, did Mr. Smith have respiratory problems?

A. We know he had lung cancer and we know he was being treated for chronic obstructive disease.

Q. And we know from the pulmonary function studies that

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all the measures of obstruction were less than 5[illegible] percent of predicted; we know that, don't we?

MR. SHEFFLER: Objection, pulmonary function studies speak for themselves.

A. That isn't a correct statement, either.

Q. (By Mr. Scruggs) All right. Mr. Smith's pulmonary function studies indicate that his -- that the values you look to to determine obstruction were impaired?

A. Yes, they were.

Q. Do you have any reason to believe that Mr. Smith did not have COPD?

MR. SHEFFLER: Objection, we've been over this now, Dick, for a number of times.

MR. SCRUGGS: I'm trying to hurry this through so I can rule some things out.

A. I believe he did have COPD.

Q. (By Mr. Scruggs) Was his COPD one of the reasons that Mr. Smith's doctors decided not to attempt to operate on his lung to remove the cancer?

A. I believe that's -- that was a contributing event, yes.

Q. Doctor, are you presently following any patients who have COPD?

A. Oh, yes.

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Q. What percent of the patients you're now following are you treating for COPD?

A. I have no idea. I mean, do I have patients that I have and in the past and are currently treating for COPD? Yeah. Do I consult on them all the time? Yes. Do I see them week in and week out? A relatively small percent, because that's not the nature of my practice.

Q. You do not specialize in treating respiratory complaints, do you?

A. You didn't ask that.

Q. I'm asking it now.

A. I certainly do. But let me qualify that one and save you a whole lot of time. I'm an infectious disease doctor. We treat TB, we treat histoplasmosis, sporothrichosis, pneumonia and microplasma and chlamydia and influenza, and all those involve the respiratory tract at one time or another. So do I deal with the respiratory tract with some regularity? Yes, I do.

Q. Are you prescribing treatment now? Are you the leading treating physician on patients with COPD?

MR. SHEFFLER: Objection. Which question do you want to ask?

Q. (By Mr. Scruggs) Are you treating patients today

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for COPD?

MR. SHEFFLER: Objection, he answered that question.

Q. (By Mr. Scruggs) What percentage of the patients are you treating today?

MR. SHEFFLER: Objection, asked and answered.

MR. BARRETT: If you'll let him answer. If he --

MR. SHEFFLER: We're repeating --

MR. BARRETT: You're keeping him from saying "yes" or "no," and it takes three or four minutes instead of just letting him say "yes" or "no" and we can move on.

MR. SHEFFLER: You're not supposed to ask the same question three and four times looking for a different answer.

THE WITNESS: I honestly believe I have answered that question, but I will try it again for you.

MR. SCRUGGS: Thank you.

A. If someone has a pure respiratory problem, I'm going to refer that patient. But do I see patients who have chronic lung disease who have other problems? Answer, yes. Do I interact with patients with

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chronic obstructive lung disease, emphysema, bronchitis, all the rest of them? The answer is yes.

If you ask what percent of patients that I treat in the longitudinal long-going basis, the answer is a very small percentage, because they much more relevantly belong under the plan of the pulmonary doctor. So I don't follow any of them in that respect. But do I see patients with these concurrent morbidities as part of my practice, every day in a large percent. And since the lung is one of the areas that's infected with some frequency, it would constitute a fair degree of my practice. But the question you've asked doesn't lend itself to a simple answer.

MR. UPSHAW: You won't be able to give a better answer than that.

MR. SCRUGGS: I'm not going to ask it again.

Q. (By Mr. Scruggs) Doctor, is emphysema caused by infectious disease?

A. Some are.

Q. Do you believe Mr. Smith's emphysema was caused by --

MR. SHEFFLER: Objection.

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Q. (By Mr. Scruggs) Do you believe Mr. Smith had emphysema?
A. I don't know whether Mr. Smith had emphysema or not.
Q. Do you believe Mr. Smith had -- strike that. What are the signs and symptoms of emphysema, clinically?
A. They vary from absolutely no symptoms at all to being bedridden as a respiratory cripple, and all gradations in between there.
Q. Is there anything about Exhibit 4 or 5 that would lead you to believe Mr. Smith did not have emphysema?

MR. SHEFFLER: Objection to that question.

A. There is no way you can answer that question off these pulmonary function data.
Q. (By Mr. Scruggs) Pulmonary function studies are not important in diagnosing emphysema?

MR. SHEFFLER: Objection.

A. I don't recall saying that.
Q. (By Mr. Scruggs) Is it your opinion pulmonary function studies are important in diagnosing emphysema?
A. I testified to the fact that diagnosing any respiratory disease, that the history is important, the physical exam is important, the x-ray is

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important, the blood gas is important, the physiologic measurements of lung function are important and the progression over time or changes in time and changes in response to therapeutic modalities are important. Even such things as CAT-scans of the chest and various ventilation profusion scans are important. There are -- all of those are important in a given case.

Q. Are pulmonary function studies important in diagnosing emphysema?

MR. SHEFFLER: Objection, asked and answered.

A. I answered that.

Q. (By Mr. Scruggs) No, you haven't. You told me a whole lot of other things were. It's a simple question. Are they or are they not important in diagnosing emphysema?

A. As one of a whole assessment.

Q. Fine. So they are important?

A. Yes.

Q. Thank you. Now, Doctor, what is it -- what values in a pulmonary function study are consistent with the diagnosis of emphysema?

MR. SHEFFLER: Objection.

MR. SCRUGGS: Just can't stand it,

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huh?

A. Oh, I suppose the single most important one --

MR. SHEFFLER: He didn't ask you that, Doctor. He asked what ones are consistent.

A. Any one are consistent.

Q. (By Mr. Scruggs) I'm sorry?

A. Any and all of them are consistent.

Q. All right.

A. And I've already qualified this by saying it depends on the stage of the illness you're having.

Q. Doctor, is the forced vital capacity important in assessing a patient for emphysema?

MR. SHEFFLER: Objection.

A. It's one of the tests.

Q. (By Mr. Scruggs) What's the most important value you look for in a pulmonary function study in assessing the patient for emphysema?

A. **Arterial blood gases.**

Q. I'm talking about a pulmonary function study, Doctor.

A. It's one of them.

Q. Not blood gases.

A. It's one of the pulmonary functions -- you're talking about ventilatory mechanical studies.

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Q. I'm talking about pulmonary function studies.
A. Blood gases are a pulmonary function study.
Q. I won't quibble with you on that, Doctor. I don't think you'll find many pulmonologists that will agree with that.
A. They wouldn't never try to interpret it without it.
Q. Well, is Exhibit 4 and 5 a pulmonary function study?
A. I don't know. What do they call it?
Q. It's what we've been calling it all afternoon.
A. I think they are calling it spirometry.
Q. We never used that word today, have we, Doctor?

MR. SHEFFLER: Objection. Are you arguing with the witness on the definition of Exhibit 4 or what?

MR. SCRUGGS: I think he's arguing with me.

Q. (By mr. Scruggs) Are Exhibit 4 and 5 pulmonary function studies or not?
A. They are part of pulmonary function studies. These are pulmonary mechanic studies.
Q. Do either Exhibit 4 or 5 give a value for arterial blood gases?
A. Over here --
Q. What about Exhibit 5?

MR. SHEFFLER: Let the record reflect

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the doctor is indicating Exhibit 4 does have arterial blood gases noted.

Q. (By Mr. Scruggs) Arterial blood gases for Mr. Smith, represented by Exhibit 4, show what?

A. Show minor --

MR. SHEFFLER: What he wants you to do is read what they say.

MR. SCRUGGS: I want you to interpret them for me.

MR. SHEFFLER: You didn't ask that.

MR. SCRUGGS: Yes, I did.

Q. (By Mr. Scruggs) But go ahead. Interpret them for me.

A. I would interpret that to indicate that he has a minor degree of arterial hypoxia, normal PH --

Q. What is --

A. -- without CO2 retention.

Q. What is hypoxia?

A. It's a reduction in the amount of oxygen carried by the the hemoglobin.

Q. Is that consistent with emphysema?

A. It's consistent with hypoxia.

Q. Is hypoxia consistent with emphysema?

A. It's one of the causes of hypoxia.

Q. Emphysema will cause hypoxia?

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A. It may.

Q. Besides arterial blood gases, what do you look for in a pulmonary function study as an important factor in diagnosing emphysema?

A. You would have to look at the entire pulmonary function. By the way, these are called pulmonary mechanics, by the way, on their own form, not pulmonary function studies.

Q. Okay, Doctor. I asked you before we started this if you had looked at pulmonary function studies, and these are what you produced to me. These are what you called them, not me.

Now, what other values on Exhibits 4 and 5 are important in assessing the patient?

A. Actually, Mr. Scruggs, all of them are important.

Q. All of them are important?

A. All of them are important and all of them have to be taken in the context of the whole picture.

Q. We'll get to the context in a minute. I'm talking about this particular part of the puzzle.

A. Okay.

Q. What is it about Exhibit 4 or 5 that would indicate that Mr. Smith did not have emphysema?

A. The biggest argument against it is that his forced vital capacity was reduced, which would indicate

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that he had a fair degree of restrictive disease. And the question of whether restrictive disease was in the lung or in the chest wall, you can't really say.

Q. Doctor, he had a mass in his lung at the time these tests were taken, did he not?

A. He had a mass in one lobe of his lung, which wasn't completely occluding a bronchus, yes, he did.

Q. Would a mass of that nature tend to make the forced vital capacity increase or decrease in capacity?

A. If it's not interfering with air flow, it shouldn't change it a whole heck of a lot.

Q. Would it increase it or decrease it, Doctor?

MR. SHEFFLER: Objection, just answered the question.

A. It would take an awfully large mass to interfere with air flow, with the measured force expiratory volume.

Q. (By Mr. Scruggs) Would a mass such as that which Mr. Smith had in his lung increase or decrease his forced vital capacity?

MR. SHEFFLER: Objection. Or leave it unchanged. Your question assumes it would increase or decrease.

A. In answer to the question, I really don't think the

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mass, as described to me on the x-rays and on the bronchus copy, would have much effect on air flow.

Q. (By Mr. Scruggs) I wasn't talking about air flow again, Doctor.

A. Well, as measured --

Q. Talking about lung volume.

A. As total expiratory volume.

Q. Other than a reduction in forced vital capacity, what is it about Mr. Smith's studies, Exhibit 4 and 5, that would lead you to believe that he did not have emphysema?

A. Well, I don't think anything else would lead me to believe that he didn't have emphysema.

Q. Would you agree, then, that the other values other than forced vital capacity on Exhibits 4 and 5 are consistent with the diagnosis of emphysema?

A. They are consistent, but by no means diagnostic of.

Q. They are consistent with a diagnosis of emphysema, other than forced vital capacity?

A. That's like saying they are consistent with athletes foot. It can occur, but it doesn't necessarily mean it's directly related to it.

Q. I didn't ask you that.

A. I understand that. But the implication is that by saying it isn't inconsistent, would make it

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consistent with or diagnostic, and I wouldn't concede that to you.

Q. Doctor, I'm not asking you at all whether the pulmonary function studies are diagnostic of anything. I'm simply asking you is there anything other than the reduction in forced vital capacity that would be inconsistent with the diagnosis of emphysema in Mr. Smith.

Doctor, do you typically do a forced vital capacity or pulmonary function study on a patient for the assessment of athletes foot?

A. No, but some patients with athletes foot do have obstructive lung disease.

Q. All right, Doctor. Answer my question and we'll move on.

A. I believe I have answered your question. And I don't think there is anything in these that either exclude or diagnose emphysema.

Q. All right. Are there anything other than forced vital capacity reduction in Exhibits 4 and 5 that are inconsistent with a diagnosis of emphysema?

MR. SHEFFLER: Objection. He's answered that question.

MR. SCRUGGS: He has not answered that. He gave me the same BS answer he just

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gave me.

MR. SHEFFLER: He just told you that there is nothing that is diagnostic one way or the other.

MR. SCRUGGS: That was not my question, Bruce.

MR. SHEFFLER: If it's not diagnostic --

MR. SCRUGGS: I'm talking about consistent with the diagnosis. I'm not talking about diagnostic.

MR. SHEFFLER: It cannot be diagnostic one way or the other; it can't be consistent one way or the other. He's answered the question three times.

MR. SCRUGGS: Now, that's just pure bull.

Q. (By Mr. Scruggs) Doctor, I'm going to ask it one more time. Is there anything in Exhibits 4 or 5, other than a reduction in forced vital capacity, that would be inconsistent with a diagnosis of emphysema in Mr. Smith?

MR. SHEFFLER: Asked and answered.

A. I've answered the question.

Q. (By Mr. Scruggs) Well, answer it again for me.

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A. Pulmonary function tests neither diagnose or exclude emphysema as a possibility.

Q. Doctor, you said a minute ago that pulmonary function studies were important among many other things in diagnosing emphysema.

MR. SHEFFLER: Objection.

Q. (By Mr. Scruggs) And I'm asking you about one piece of that puzzle. Is there anything other than a reduction of Mr. Smith's forced vital capacity that is inconsistent, in Exhibits 4 or 5, with the diagnosis of emphysema?

MR. SHEFFLER: Asked and answered.

A. With the usual qualifying remarks I've already made, no.

Q. (By Mr. Scruggs) Thank you. Doctor, is there anything in Mr. Smith's medical history or anything in the records you've looked at on Mr. Smith, other than what we talked about as a reduction in forced vital capacity, that would lead you to believe Mr. Smith did not have pulmonary emphysema?

MR. SHEFFLER: Objection. As you sit here, you can answer.

A. I stand by what I've already said, and I've commented on it a variety of ways, is that emphysema may be a disease that is totally asymtomatic and

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inconsequential to one which is pulmonary. And could he have emphysema? Sure.

Q. (By Mr. Scruggs) My question, Doctor, was: Is there anything in the medical records of Anderson Smith that you read that is inconsistent with the diagnosis, or that would lead you to believe that Mr. Smith did not have emphysema, other than a reduction in his forced vital capacity?

A. With the usual qualifying remarks I've already made, the answer is no.

Q. As you sit here today, can you say that it is more likely than not that Mr. Smith did not have emphysema?

A. I can't say that.

Q. Doctor, do you have an opinion as to whether Mr. Smith had emphysema?

A. Not really.

Q. Doctor, do you believe that Mr. Smith had a carcinoma, a squamous cell carcinoma in his right upper lobe at the time of his death?

A. Yes.

Q. Do you have an opinion as to the cause of that carcinoma?

A. I don't think anybody knows what causes carcinoma.

Q. Is that true in general?

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A. All carcinomas?
Q. Yes.
A. I think there are a bunch of theories out there on carcinoma, but I don't think anybody knows what causes it.
Q. Is it your opinion, Doctor, that tobacco smoke contains carcinogens?
A. **Tobacco smoke contains carcinogens.**
Q. Do you know of any carcinogen other than tobacco smoke that Mr. Smith was exposed to, based on your review of his records?
A. I would have to speculate.
Q. Well, think about my question a minute. Don't speculate.
A. Well, again, medical records leave a lot to be desired.
Q. Anything that you've seen on Mr. Smith to date?
A. **The carcinogens, the term that you talk about, carcinogens, are those agents which are associated with the production of tumors in experimental animals --**
Q. All right. Doctor, are you saying tobacco smoke is carcinogenic only to experimental animals?
MR. SHEFFLER: Objection.
A. I don't think I said that.

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Q. (By Mr. Scruggs) I'm asking if you are saying that.
A. I didn't say that.
Q. Are you saying -- do you believe that?
A. You asked me whether --
Q. Does tobacco smoke --
A. -- it contains carcinogens.
Q. Contains carcinogens. All right.
A. Complex hydrocarbons.
Q. Does tobacco smoke contain human carcinogens?
MR. SHEFFLER: Objection.
A. I don't know.
Q. (By Mr. Scruggs) Well, to what organism is tobacco smoke carcinogenic?
MR. SHEFFLER: Objection.
A. You're asking a series of questions that call for me to speculate on things, and I don't really know.
Q. (By Mr. Scruggs) I'm just asking your opinion, Doctor.
MR. SHEFFLER: If you don't know, that's an answer.
A. I don't know.
Q. (By Mr. Scruggs) Will the carcinogens in tobacco smoke cause cancer in humans?
A. I don't know that.
Q. Doctor, is it more likely than not that carcinogens

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in tobacco smoke are carcinogenic in humans?
A. I don't know the answer to that.
Q. Is that beyond your field of expertise?
A. It sure is.
Q. Can you say within a reasonable degree of medical certainty that smoking cigarettes did not contribute to the squamous cell carcinoma in Anderson Smith?
A. I don't know.

MR. SHEFFLER: Can I go off the record a second?

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, do you believe there is an association between tobacco smoke and cancer in humans?
A. Yes, I do.
Q. Do you know of any substance that has a greater association than tobacco smoke to cancer in humans?

MR. SHEFFLER: Objection to the form of the question, I think it's an improper use of the word. I specifically object to the use of the words, "greater association," in terms of that question.

A. Sunlight, maybe.
Q. (By Mr. Scruggs) Okay. Do you believe that cancer -- that sunlight causes lung cancer in

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humans?

MR. SHEFFLER: Objection. He's already testified he doesn't know what causes cancer.

MR. SCRUGGS: Come on, Bruce, we are going to be here all night. Let the man talk.

MR. SHEFFLER: You're asking the same questions again.

A. Didn't you ask me about cancer in general a minute ago?

Q. (By Mr. Scruggs) I asked you if tobacco smoke -- I asked you a cause first of all, and you said you didn't know. I said does tobacco smoke cause cancer in humans and you said you didn't know. Now I've asked you if tobacco smoke is associated with cancer in humans, and you said yes.

A. Yes.

Q. **Is tobacco smoke associated with carcinogenic carcinoma in humans?**

A. **Yes.**

Q. Do you know of any substance that has a stronger association of lung cancer in humans than tobacco smoke?

MR. SHEFFLER: Object to the use of

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the word "stronger."

A. I don't really know the answer to that question.

Q. (By Mr. Scruggs) What other substances are associated with carcinogenic carcinoma in humans other than tobacco?

A. There are a whole heck of a lot.

Q. Okay. Let's do them. Are any of those, that whole heck a lot of, have a stronger association, in your opinion?

MR. SHEFFLER: Objection.

A. I don't know. I mean --

Q. (By Mr. Scruggs) Did Anderson Smith --

A. This is something I don't hold myself out to be an expert on. I've been aware of an association in broad context of usable information. I can make a catalog list, if you like.

Q. What other carcinogens, or what other substances that have an association with carcinogenic carcinoma other than tobacco smoke was Anderson Smith associated with, according to your review of the records?

A. In the records somewhere it says he was exposed to forestry or wood cutting or something back once upon a time.

Q. What else?

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A. And I really don't know what his job was in the army.

Q. Is being in the army associated with lung cancer in humans, Doctor?

A. Could conceivably be.

Q. Okay. He served in the army and he has wood cutting in his background?

A. Uh-huh.

Q. And both of those things you believe could be associated with lung cancer in Mr. Smith?

A. Well, the -- yeah, conceivably. You certainly can have lung cancer without exposure to any known associated factor.

Q. I'm just asking you if there are any known associated factors in Mr. Smith's history other than cigarette smoking, wood cutting and being in the army?

A.

Q.

A.

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Q.

A.

Q.

A.

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Q. Is there an association between alcohol use and bronchus carcinoma in humans?
A. I'm not aware of any at this moment.
Q. What other substances that have an association with cancer, with lung cancer in humans, was Mr. Smith exposed to, according to what you know today?
A. Only those that everybody else is exposed to.
Q. Such as?
A. Such as asbestos and silicon and radon and --
Q. Is there anything that you have read, as you sit here today, that would lead you to believe that Mr. Smith was exposed to asbestos?
A. No. But everyone is to some extent.
Q. You don't know that for a fact in Mr. Smith's case, do you?
A. No.
Q. What about silica?
A. I don't know that either.
Q. What about radon?
A. Again, it's sort of hard for any of us to miss all of those.
Q. I understand, Doctor. But from the review of the records you've seen here --
A. No. No, you're right. None specifically are tabulated, although he's not had a detailed

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environmental history recorded on him.

Q. All right, sir. I understand that --

MR. SHEFFLER: He's only asking you, Doctor, for specific things in the record that you reviewed that would indicate an exposure to a risk factor for lung cancer.

THE WITNESS: I'm sorry, I was trying to set the pace because of the way he's behaved in the past.

MR. SCRUGGS: I told you they beat me up.

A. Every conceivable question -- I mean, I don't know what kind of dye he uses in his shoes.

Q. (By Mr. Scruggs) Doctor, I'm asking a specific question. Do you know of any substance other than tobacco smoke that Mr. Smith was exposed to that has an association with lung cancer in humans?

A. Not that I'm aware of from the record.

Q. What is your definition of a carcinogen? Would it be fair to say it's a substance that will produce cancer?

A. I think you would have to qualify that. I think it would be -- that is a starting point with qualifiers. And by that, I think you have to talk in terms of concentration, duration, amount,

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species, other co-factors that are there in defining what is a carcinogen.

A carcinogen, in my definition, would be an agent that would reliably and reproducibly produce a pathologic effect, in this case, carcinoma, in which you could define dose limits and exposure times. And those things simply have not been established for people for any carcinogens or carcinogens in animals. They can be worked out in hamsters, they can be worked out in rats, they can be worked out in a whole bunch of other experimental animals, but extrapolating what goes on in animals and what goes on in people requires a giant leap of faith.

MR. SCRUGGS: Let's take a break.

(Brief recess.)

MR. BARRETT: Can we agree that we will continue this deposition for another hour and a half or so and then reconvene it in the morning at 8:00 o'clock, you want to say -- would that be better for you all? -- and go for another, not exceeding noon, and that we will cancel for tomorrow the deposition of Dr. Nunez, N-u-n-e-z, by agreement, and reconvene it as soon as it's practical for both sides, that is as soon as

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we get an open date and get him an open date, but you all won't hold us to the February 15th discovery cutoff. Is that agreeable?

MR. SHEFFLER: It's agreeable to the extent to which we expect you to be equally cooperative in scheduling and deposing Dr. Smalls or Dr. Pelle, whose depositions, if continue over for more than a day, we expect the same reciprocity.

MR. BARRETT: Well, we hope to -- we think eight hours is enough for anybody, but we will certainly give you eight hours for both of those guys without any fussing about it. And I'm considering doing this because Jim doesn't want you all to have -- you all have flight connection problems and we're here in a private plane and we can get back for the deposition tomorrow. I mean, I'm offering to cancel the deposition tomorrow for you-all's convenience, not mine. So I'm not asking for any concessions on that, if you all want to do it.

MR. SHEFFLER: Five hours today and four tomorrow is more than eight hours. I'm

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just saying we expect the same consideration from you.

THE WITNESS: Let me put a proviso in there. I blocked out this afternoon's schedule. I don't think I have anything overtly scheduled, but I've been calling my secretary. I don't know what the hell is happening tomorrow. The meeting at noon tomorrow means I've got to be there at noon, and it's in Alvin, so I've got to be out of here by about 11:00.

MR. UPSHAW: What if we start at 7:00 in the morning? We don't mind you giving another four hours tomorrow. You go another hour and a half today, you've got five or six, it's a total of nine or ten hours. All we ask is we get the same. We don't necessarily want that on most of them.

And I think it would be more appropriate in the rescheduling, we can't reconvene Nunez, because we haven't started him, but we will reschedule him. Your choice of words was not too good. But anyway, we're communicating. We know what we're talking about. We've got no problem

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with that. You're talking about going here now until 6:00 o'clock, in other words?

MR. BARRETT: Probably 5:30 or 6:00.

MR. UPSHAW: Until you find a good stopping point. Fully understanding you're not going to get over four hours in the morning, because the man has got to be somewhere. He's being nice to agree to do this.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, before we broke, I asked you what your definition of a carcinogen was, and I'm going to ask you again. What is your definition of a carcinogen?

MR. SHEFFLER: I object. He answered that question. If you would like the record to be read back --

MR. BARRETT: No, it would be quicker to go ahead and answer the question.

MR. SHEFFLER: I object to the process. Read the record back.

MR. BARRETT: Go ahead and answer the question, move on.

THE WITNESS: I've answered your question.

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MR. BARRETT: Are you refusing to answer the question?

MR. SHEFFLER: He said he answered. That's an answer.

MR. BARRETT: No, that's not an answer.

THE WITNESS: I will answer it again, but I sort of like my previous answer.

MR. BARRETT: Give it again.

Q. (By Mr. Scruggs) Doctor, let me ask you something. Can you give me some examples of substances that you would consider to be a carcinogen?

A. In answer to the question, it largely depends on whose definition of what a carcinogen is.

Q. I'm using your definition.

A. I'm trying to use the one I previously mentioned to you. Carcinogens are really defined in the effects of time dose relationships of different pure compounds existing by themselves in experimental animals, and that in which you could get a predictable cause and effect relationship out of that. There are a variety of these. And many of the various hydrocarbons that are present in gasoline, hydrocarbons that are present in petroleum distillates of one type or another, benzene, many,

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many, many different chemical agents have been labeled in the carcinogens.

The critical issue here is the carcinogens may be carcinogenic for one species and not for another. And in finding what particular species that animal responds to is what constitutes the definition from that.

Q. Doctor, let me ask you another question. If you continued --

A. It's a very, very broad question, and the important question is that you can't extrapolate from experimental animals directly to people.

Q. Doctor, would you name me a substance that you believe is a carcinogen in humans?

A. Papilloma virus.

Q. Papilloma virus. Give me another substance.

A. How about a Hepatitis B virus. Hepatitis C virus.

Q. All right.

A. These are not pure substances. These are living creatures that replicate and in the process of growing, produce inflammatory changes in tissue.

Q. Can you name a non-viral substance that is carcinogenic in humans?

A. Microbacterium tuberculosis.

Q. Can you name a non-organic substance that is

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carcinogenic in humans?

A. Sunlight.

Q. What else?

A. I suspect anything in the proper dosage has been associated at one time or another.

Q. Does the fact that a substance is associated with cancer in humans mean it is carcinogenic?

A. Not necessarily.

Q. Then why do you think sunlight is a carcinogenic in humans?

A. Because of its association with degree of sun exposure. But even that context has to be predicated upon the genetic background of the individual having the sun exposure. The sun exposure in the fair skinned, blonde haired person constitutes a lot more risk than in the darker skinned, darker haired individual.

Q. Is there any other reason besides the association between sunlight and cancer to humans that lead you to believe that sunlight is carcinogenic in humans?

A. I'm sorry, I don't understand your question.

Q. Other than an association between sunlight and cancer in humans, what else leads you to believe that sunlight is carcinogenic in humans?

A. Again, I don't know that I would say that it is.

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There are other properties of sunlight that I would throw in that would -- for example, individuals having sun exposure on their lips are very likely to reactivate latent viruses, like herpes. And they have to ask the question, "Why do these reactivate," except that probably -- and that calls for speculation -- it's probably that sunlight affects local immune functions that contain viruses in place and that are associated with its reactivation.

MR. SHEFFLER: Doctor, let me caution you not to speculate and answer his question.

A. I'm sorry, but you're asking extraordinarily complex questions that would seem very simple on the surface, and simplistic answers don't really apply.

Q. (By Mr. Scruggs) I'm simply asking, Doctor, what inorganic substances other -- I'm asking this now. **What inorganic substances other than sunlight are human carcinogens?**

A. **Talc.**

Q. Okay.

A. **Silica.**

Q. Okay.

A. I don't know, probably a whole bunch. It's a hostile world out there.

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Q. Talc, silica, sunlight --

MR. UPSHAW: You could suggest asbestos.

MR. SHEFFLER: Wait. Let's -- Doctor, if you can answer the question, answer the question from whatever information you have, but not Mr. Upshaw.

A. I'm not an expert in that area.

Q. (By Mr. Scruggs) You're not an oncologist?

A. Even oncologists -- you're really asking for oncotoxicologist.

Q. Doctor, I'm trying to get an idea of substances that you think are human carcinogens.

MR. SHEFFLER: He just testified he's not an expert in oncotoxicology.

A. I don't know. I don't know. I suspect there are many more substances out there that would fall in the usual definition of carcinogens that have not yet been labeled or identified. And that's without going into the co-factors where two or three or four of them are exposed together. And that's, again, speculation.

MR. SHEFFLER: Please don't speculate.

(Discussion off the record.)

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Q. (By Mr. Scruggs) Is it more likely than not, Doctor, in your opinion, that cigarette smoke will cause lung cancer in humans?

A. I didn't say that.

Q. I didn't ask you if you said it. I asked you if it is your opinion?

A. I said I believe that cigarette smoke is associated with the presence of lung cancer, but that if you ask me does cigarette smoking cause lung cancer, the answer is no.

Q. I'm asking is it more likely than not that it causes lung cancer?

A. The answer is no.

Q. It's your opinion it's not more likely than not that cigarette smoke causes lung cancer in humans?

MR. SHEFFLER: Objection to the double negative in the question. Can you rephrase the question?

(Discussion off the record.)

MR. SCRUGGS: All right, sir. That's fine. All right.

Q. (By Mr. Scruggs) Does cigarette smoke cause emphysema in humans?

A. It's associated with emphysema.

Q. Based on your review of Anderson Smith's medical

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records, is there any substance other than cigarette smoke that he was exposed to that is associated with emphysema?

A. No, not that I can recall.

Q. Is obstructive lung disease, chronic obstructive lung disease associated with cigarette smoke?

A. It has been.

Q. In humans?

A. Sure.

Q. Do you see anything in Mr. Smith's medical records or anything you've examined in this case that leads you to believe that Mr. Smith was associated with or was exposed to any other substance besides cigarette smoke that is associated with chronic obstructive lung disease?

A. You asked about -- the answer to that is no.

Q. Does cigarette smoke have an effect on mucociliary clearance in humans?

MR. SHEFFLER: Objection. Unless you define what you mean by "affect."

A. Answer, I don't know whether it does in humans or not. I'm not aware of any human studies having been done. There are a number of animals studies shows that cigarette smoke impairs mucociliary clearance.

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Q. (By Mr. Scruggs) Do you have any reason to believe it does not impair mucociliary clearance in humans?
A. No. You're talking about the mucociliary --
Q. Yes. Can tobacco smoke impair the immune system in humans?
MR. SHEFFLER: Are you asking is it possible?
MR. SCRUGGS: Yeah
MR. SHEFFLER: Object. Anything is possible.
A. I don't know the answer to that.
Q. (By Mr. Scruggs) Is tobacco smoke associated with impaired immune function in humans?
A. I don't know.
Q. Is tobacco smoke associated with increased respiratory infections in humans?
A. Interestingly enough, it probably is not. There has been one study that I saw several years ago on fully defined respiratory, URI, colds, that type of thing, appear to be no major difference in smokers than non-smokers.
Q. Do you recall the name of that study?
A. No.
Q. Only one study you've seen to that effect?
A. It was sort of remarkable, because it sort of went

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contrary to what the usual dogma is.

Q. The usual dogma based on other studies?

A. No, the usual dogma based on people's opinions.

Q. Is it your opinion, Doctor, that cigarette smoke does not impair the immune system in humans?

MR. SHEFFLER: Objection. That's not what he testified to. He says he didn't know.

Q. (By Mr. Scruggs) Is that the answer, you don't know?

A. The answer is I don't know, but I will further say that it would depend on how much, how long, when and by what measures one was measuring the immune studies. And if you're aware of any good studies to answer that question, I will be delighted to receive them from you.

Q. I did misstate the question. Is it your opinion that tobacco smoke does not impair or does not increase risk of respiratory infections in humans?

MR. SHEFFLER: Objection. He's answered it.

A. That was another question, but --

Q. (By Mr. Scruggs) I know.

A. My personal bias is that it may, but supporting that with hard data is very difficult to do.

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Q. Doctor, did you testify earlier that you're presently following patients who have emphysema?
A. I think I said that I was consulting on and had patients who had obstructive lung disease. I'm reluctant to use the diagnosis of emphysema, because by and large, that is a pathologic diagnosis in that from the standpoint of management, the question is whether they have bronchitis as reflected by cough and sputum production, or whether they have obstruction as measured by diminution of air flow. And the management of each is different.
Q. You did say that you were following patients who have chronic obstructive pulmonary disease?
A. Yeah.
Q. Are any of those patients non-smokers?
A. Oh, yeah.
Q. What percentage are non-smokers, Doctor?
A. Again, you have to qualify that and say are they non-smokers now or are --
Q. Both.
A. Well, some definitely are.
Q. Some that never smoked cigarettes?
A. Yes, sir.
Q. What percent would you estimate have never smoked?
A. Guess?

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Q. Yes.
A. Twenty, twenty-five percent.
Q. Are you presently following patients who have lung cancer?
A. Am I consulted on them? Yeah. Well, as a matter of fact, I even have one in my clinic, yeah. I'm not managing their lung cancer, that's being managed by the oncologist, but the patient has other problems.
Q. Have you ever consulted on a lung cancer case, Doctor, wherein the patient has never smoked cigarettes?
A. Sure.
Q. In what percentage of lung cancer cases you consulted in were never smokers?
A. I would guess 15, 20 percent. Primary lung cancers.
Q. I'm talking about primary lung cancers.
A. Yeah, as a matter of fact, one of my best friend's wife acquired lung cancer and had never been near a cigarette.
Q. So 20 to 25 percent of the patients that you're consulting, that you have consulted for lung cancer, have never smoked cigarettes, in your estimation?
A. That's what they tell me.
Q. That's taking a medical history, right?
A. Yes.

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Q. And do you believe it? Do you believe the history?
A. I have no reason not to.
Q. Doctor, do you presently follow patients or consult with patients who have respiratory disease that is of a non-infectious nature?
A. Sure.
Q. Let's go over your daily routine for a few patients. You're on a number of committees that I can see in your CV; is that correct?
A. Yes.
Q. In fact, we've listed -- I'm going to start off with your Exhibit 3, which is your out-of-date CV. Under "Committee Responsibilities," it says you are currently, correct me if this is changed, on the residency advisory committee?
A. I'm its chairman.
Q. You're the chairman of the residence advisory committee?
A. Yes.
Q. What percentage of your time, of your weekly time is spent dealing with with that committee?
A. Most of the time very little.
Q. Very little. What, maybe five percent of your time?
A. Appreciably less than that. I can save you a lot of time. If you want to know how I spend my day, I'll

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tell you.

Q. Sure.

A. As far as that concern, that has to do with advising senior medical students as to what their future careers would be and where would be appropriate to do residencies and training. That is pretty hectic in the fall, and it's very, very hectic between the 15th and 17th of May when their match comes out and they are matched for internships. A lot of responsibility.

Before that time, it's basically just there. I'm a teacher at the university. My principal role is that of teaching. I have one scheduled clinic where I see out-patients each week, and that's Wednesday afternoon.

Q. Let me stop you right there.

A. And I see a number of patients who develop acute infections and want me to see them in consultative capacity at one time or another throughout the week. Between four and six months a year I attend on a ward, in which I'm the physician of record and principally responsible for a ward of between 12 and 16 patients at all times.

And between four to six months out of the year, I'm primarily responsible for the infectious disease

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consultation service, in which I see patients that are directed to us that either do have or could have or will have an infection of some type. A fair number of these patients are patients with cancer, patients with leukemia, patients with other co-existing medical or surgical illnesses.

The discipline of infectious diseases sees patients who could have an infection in almost any organ system, and it may extend anything from a URI to an uncomplicated urinary tract infection, to tuberculosis, to histoplasma, to gram-negative bacteriemia, to pneumonia, or you name it. And if you're asking do I see patients on a regular basis, the answer is yes. Do I see them virtually every day? The answer is yes.

Q. All right. All right, Doctor. You were board certified in internal medicine in 1966?

A. Right.

Q. Did you pass the board the first time?

A. Yeah.

Q. What about infectious diseases, did you pass that board the first time?

A. I did.

Q. Have you sat for any boards besides those two?

A. No.

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Q. Does board certification in infectious diseases imply a special expertise in lung diseases of a non-infectious nature?

A. No, only that you have to have a fairly broad usable knowledge in order to practice your discipline.

Q. Have you ever been a member of the American Thoracic Society?

A. Huh-uh. Could have.

Q. You just chose not to?

A. Uh-huh.

Q. What about the American College of Chest Physicians?

A. I could belong to that, too. I pay enough dues.

Q. Are there physicians who specialize in infectious diseases who are members of those two organizations?

A. Sure. I get enough journals. I pay enough dues.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, do you smoke cigarettes yourself?

A. No, sir.

Q. Have you ever?

A. No.

Q. Why not?

A. I haven't wanted to.

Q. Do you believe that smoking cigarettes increases the risk of respiratory disease in humans?

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A. In a broader sense, sure.
Q. And when you say in a broader sense, what do you mean?
A. Respiratory disease is a God awful composite.
Q. Does anybody in your immediate family smoke cigarettes?
A. My mother did.
Q. Is she still living?
A. Yes.
Q. Is she free of any respiratory complaints?
A. Yeah, she's got some allergies.
Q. Has she ever been diagnosed with bronchogenic carcinoma?
A. No.
Q. COPD?
A. No.
Q. Emphysema?
A. No.
Q. Bronchitis?
A. She hasn't been diagnosed with it, but she's got it.
Q. She's got bronchitis?
A. Uh-huh.
Q. Is that as a result of an allergic reaction?
A. Probably.
Q. Do you think her smoking cigarettes contributed in

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any way to her bronchitis?

A. No.

Q. You have several children, I noticed on your CV, Doctor. Any of them smoke cigarettes?

A. Oldest one.

Q. Does he?

A. She.

Q. Have you ever made a recommendation to her about smoking or not?

A. You bet.

MR. UPSHAW: Off the record.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, have you counseled your daughter not to smoke cigarettes?

A. Sure.

Q. Why did you counsel her not to smoke?

A. I don't like it.

Q. So you told her not to smoke around you or not smoke at all?

A. Both.

Q. Is it the fact you don't like cigarette smoke yourself or that you don't like your daughter smoking cigarettes?

A. Both.

Q. Why do you not want your daughter to smoke

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cigarettes?

A. Well, first of all, it's a dirty, nasty habit and it costs a lot of money. Secondly, you smell bad all the time. And third, that it's associated with a bunch of bad problems.

Q. Bad health problems?

A. Yes. And I would recommend you not smoke, either.

Q. You don't have to, Doctor. I've taken that recommendation. Has your daughter ever attempted to quit smoking?

A. Halfheartedly. She doesn't really want to stop.

MR. BARRETT: I didn't hear that.

MR. SCRUGGS: She doesn't really want to stop.

Q. (By Mr. Scruggs) Does it take a strong motivation to stop smoking for most people?

MR. SHEFFLER: Objection. Objection to the question.

A. You're asking an opinion?

Q. (By Mr. Scruggs) Yes.

MR. SHEFFLER: Objection to the question as to qualify the doctor as an expert in decision making by smokers.

A. I think it's about as hard to stop smoking as it is to go on a diet.

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Q. (By Mr. Scruggs) Doctor, judging -- how hard is it to go on a diet, Doctor?
A. Actually, it's very easy.
Q. How hard is it to stay on a diet?
A. Harder. It's all a matter of willpower.
Q. Does it take a substantial amount of willpower to stop smoking in most people?
MR. SHEFFLER: Objection.
A. Well, I really haven't tried it myself, but I do know it's hard to stay on a diet.
Q. (By Mr. Scruggs) You're talking -- Doctor, do you counsel your patients not to smoke?
A. Oh, I do. I do it very vigorously. As a matter of fact, the ones that I have, I won't continue to take care of them as long as they do smoke.
Q. And why is that? Same reasons you ask your daughter not to smoke?
A. By and large, yes. Again, it's a compliance issue with the program.
Q. And what program --
A. If they are not willing to invest in the program, I'm not going to invest in it either.
Q. What program is that?
A. The one for which I'm treating them. You asked if I'm treating someone with chronic obstructive lung

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misstate his testimony or you're not listening to what he's saying.

MR. SCRUGGS: I'm not misstating anything. I'm asking a question.

Q. (By Mr. Scruggs) Do you think smoking cigarettes exacerbates emphysema?

A. I can give you the proviso that I had before. I think emphysema is a complex issue caused by a lot of different things, and there are a number of factors that come to bear on it. And the ones that are eliminated, that are elimitable, should be eliminated.

Q. All right. What do you counsel your emphysematous patients to abstain from, other than cigarette smoking?

A. Well, I like them to avoid getting dried out. I like them to maintain good humidity. I would prefer that they, again, within the variability, if they have known exacerbating factors, like environmental exposure, pollens, house dust, those kind of things you try to avoid, hair sprays. One of the factors which is commonly overlooked is a person with obstructive lung disease may well be currently aspirating gastric contents, and small amounts of gastric contents that enter into the lungs will

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disease, if they won't stop smoking, they will find another doctor.

Q. Is that because smoking exacerbates those conditions, in your opinion?

A. I think those conditions are complex issues that are caused by many things, one of which contributed to smoking.

Q. Does smoking exacerbate chronic obstructive pulmonary disease?

MR. SHEFFLER: Objection.

Q. (By Mr. Scruggs) In your opinion.

A. I think that certainly the association of exacerbation, lots of things exacerbate.

Q. Is smoking one of them?

A. Sure.

Q. Will smoking -- is smoking one of the things that will exacerbate emphysema?

MR. SHEFFLER: Objection, unless you define what you mean by "exacerbation."

Q. (By Mr. Scruggs) Come on, Doctor, we know what that means.

MR. SHEFFLER: He responded it's associated with many things including exacerbation, and you ask the question leaving that out. Either you try to

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produce one hell of a lot of bronchitis, tracheitis, bronchospastic.

A fair number of the patients that we have had that have been referred in with chronic bronchitis or chronic obstructive lung disease or emphysema, if you really pay attention to what they are doing, they are aspirating at bed time or in the wee hours of the morning, getting gastric contents down in to the lung which will produce one hell of an inflammatory response.

Q. My question was what substances other than cigarette smoking do --

A. I was trying to answer that. It has to be individualized for each individual patient. Say if patients with lung disease come out like from the Mrs. Baird's bread, each piece is like every other piece, the answer is not that at all. It has to be individualized from patient to patient. I think you'll find simplistically saying that if you do this, this and this, then everything will be peachy keen, that is not necessarily the way it is.

Q. Other than tobacco smoke and hair spray, household dust, what substances do you advise your emphysematous patients to avoid?

A. Anything which is known to irritate them.

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Q. To irritate the respiratory tract?
A. Yes.
Q. Would cigarette smoke be one of those things?
A. It would.
Q. Be known to irritate the respiratory tract?
A. Sure.
Q. Do you advise patients who have no respiratory complaints to stop smoking?
A. As part of the general health assessment, sure. I don't think you'll hear me say smoking is good for you, or obesity is good for you.
Q. I'm going to ask you that. Does your hospital, Doctor, have a smoking policy?
A. Yes, it does.
Q. What is the policy?
A. The policy is there will be no smoking on campus.
Q. On campus?
A. That's what I said.
Q. That's including outside the building?
A. That's correct.
Q. How long has that been the policy?
A. For several months.
Q. Do you agree with that policy?
A. Yeah.
Q. Did you institute the policy?

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A. No.
Q. Did you -- who instituted it?
A. The president.
Q. Did he ask you for any input?
A. No. On that or anything else.
Q. Before three or four months ago, did your hospital have a smoking policy?
A. Uh-huh.
Q. And what was the policy then?
A. None inside.
Q. None inside. And how long had that policy existed?
A. God, I don't know. Several years now.
Q. And it was just recently extended to outside the building as well?
A. Uh-huh. Go ahead and ask me how well it's enforced.
Q. Well --

MR. SHEFFLER: Don't suggest questions to him. We'll never leave. He's got enough of them.

A. I've thought of ways to enforce it.
Q. (By Mr. Scruggs) Have you ever attempted to enforce it?
A. No.
Q. Why did the, if you know, did the president of the university, or president of the college, the medical

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college or whatever --

A. University of Texas Medical Branch --

MR. SHEFFLER: Do not speculate. If you know of your own personal knowledge, answer.

Q. (By Mr. Scruggs) Do you know why he extended the policy to outside the building as well?

A. Because he wanted to.

Q. Is that like the 800 pound gorilla?

A. Yes, sir.

Q. Any other reason that --

A. Not that I know of.

Q. What's the name of the president of the UTMB?

A. Thomas N. James, Jr. And don't forget the "N" if you're going to write him.

Q. If I'm going to write him, how would I write him? What's his address?

A. **His Eminence.** Dr. Thomas N. James, Jr., M.D., President, University of Texas Medical Branch.

Q. And where is that located, Galveston?

A. Uh-huh. It will get there.

Q. Is he that well known? Okay. Is that policy in writing, the smoking policy at UTMB?

A. Well, it came down in a memorandum, and I'm sure it is somewhere in writing.

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Q. Doctor, do you know that environmental tobacco smoke is associated with carcinoma in humans?

A. I don't know.

Q. Do you believe that environmental tobacco smoke is associated with COPD in humans?

A. I don't know about that either.

Q. Emphysema?

A. Same answer.

Q. Do you know if environmental tobacco smoke is associated with any adverse health effects in humans?

A. I don't know that. I will concede it's not pleasant.

Q. You will concede that tobacco smoke is not pleasant to breathe if it's environmental tobacco smoke?

A. Yes.

Q. Doctor, what percentage of your patients who you insist do not smoke give up smoking?

A. Probably three-quarters of them.

Q. Actually give it up?

A. Yeah.

Q. Or at least they tell you they have given it up?

A. Oh, no, they give it up.

Q. And how do you know that?

A. Because I'm all-knowing and wise.

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Q. Thank you, Doctor. You'll hear that answer again.
A. They also have families.
Q. All right, sir. And so the only way you know they quit smoking is what they tell you or what their family members tell you or what you observe yourself?
A. Yeah. Besides, it's not that hard to get another doctor.
Q. Doctor, for your patients that you're following for COPD who smoked at the time of their diagnosis but who followed your advice and gave it up, did you see improvement in their condition?
A. Some do, some don't. I've had several go on to die.
Q. Even after they give up smoking?
A. Uh-huh.
Q. Is COPD -- let's put it this way, is chronic obstructive -- well, it's the same thing, chronic obstructive pulmonary disease, or COPD, reversible in most patients?
A. Depends on when you get it. It depends on when you encounter it.
Q. If you encounter it early, is it reversible?
A. Largely.
Q. If you encounter it at a moderate advanced age, is it reversible?

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A. Probably to some extent.
Q. At any stage, is it curable?
A. Depends on what you mean by "curable." Can you regenerate fibrotic tissue? Probably not. Basically I look at any of these co-factors as things that may accelerate a process; they don't necessarily cause it, but they accelerate it. And if you stop the acceleration of it -- the difficulty in talking in the abstract sense about people, is that each one of them is different and each one of them has different exacerbating features. I would submit that each one ought to be handled a little bit differently.
Q. Doctor, will cigarettes -- is cigarette smoking associated with reduction of carboxyhemoglobin?
A. I think it is.
Q. Can a reduction in carboxyhemoglobin have adverse health effects in humans?
A. Depends on the extent and duration.
Q. Let's say moderate impairment of the carboxyhemoglobin.
MR. SHEFFLER: Objection.
A. I don't really know what moderate is. You can certainly die from carboxyhemoglobin.
Q. (By Mr. Scruggs) How do you measure

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carboxyhemoglobin?

A. I think it's through spectrophotometry, but I don't know.

Q. You don't know how it's measured?

A. No.

Q. Can smoking affect the defusing capacity of the lung?

A. Probably.

Q. In what way will it affect it?

A. Well, I don't know. The whole concept of defusing capacity is one which is very hard to come by, as you well know. We would measure it in terms of defusion of carbon monoxide across the membrane. As to what that means, nobody really knows. And for the most part, we've largely abandoned using that test as a measurement of pulmonary function because of the vagaries of its interpretation of what it means.

Q. When you say we have largely abandoned the test of defusing capacity because of its vagaries --

A. Except in research capacities.

Q. -- is that just at UTMB or is it --

A. I believe it's all over the -- nationwide.

Q. Do you not use -- routinely use test of defusing capacity in analyzing a patient for the presence of

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chronic obstructive pulmonary disease?

A. I stand to be corrected, but it's been a long time since I've seen one. And the last several times I asked for one, it was not available.

Q. Doctor, you don't routinely order --

A. No.

Q. -- a test of defusing capacity in analyzing a patient for chronic obstructive pulmonary disease?

A. Once upon a time I did. And I had a fairly large population of patients with sarcoidosis. As you probably know, sarcoidosis is a defused granulomatous disease of the lung. And one of the measures of how extensive it was was to measure the DLCO.

Q. What are you trying to measure when you measure DLCO?

A. I don't know. That's why it sort of -- that's why it is largely not used -- let me take myself out of the expert category on defusing capacity of the lung, except to tell you within the very broadest context, it is a hazy area that doesn't lend itself well to precise quantization.

Q. My question is, Doctor, do you routinely ask for a defusing capacity --

A. No.

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Q. -- test in analyzing patients for lung disease, period?
A. No. No.
Q. You don't.
MR. SHEFFLER: Let him finish the question before you answer.
Q. (By Mr. Scruggs) Doctor, in a patient with emphysema, would you expect the defusing capacity to be better or worse?
A. I don't know what the defusing capacity is of emphysema.
Q. My question was, would it be better or worse in a patient who did not have emphysema?
MR. SHEFFLER: Objection.
A. I will answer the question by saying I don't know.
Q. (By Mr. Scruggs) All right. Do you believe that cigarette smoke is ciliostatic?
A. I don't have any idea. I don't know.
Q. I think you testified earlier that you thought arterial blood gases were a factor to be considered in evaluating a patient for chronic obstructive pulmonary disease?
A. That's correct.
Q. Does cigarette smoke, in your opinion, affect arterial blood gases?

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MR. SHEFFLER: Objection to the word "affect."

A. I don't know how you mean that question. Are you asking me do individuals that smoke cigarettes change their blood gases? Are you asking me if someone is actively smoking does it change --

Q. (By Mr. Scruggs) I'm asking you if the arterial blood gases in smokers in general is different from that in non-smokers?

A. I couldn't answer that.

Q. All right. Do you think that smoking cigarettes affects blood pressure in humans?

A. I don't know. Probably.

Q. Why do you say probably?

A. Just associations way back in the back of my mind. The answer is I don't know. I suspect that it probably does have effects on blood pressure, but I don't know if it's reproducible.

Q. Do you think it can affect it in a way in which blood pressure would be raised?

A. I just said I don't know.

Q. You don't know?

A. No.

Q. Doctor, do you believe that in a patient who is asymptomatic of any respiratory disease --

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A. Say that again.
Q. Any person you examine who is asymptomatic of any respiratory disease, that there is a safe level of cigarette smoking for that patient?
MR. SHEFFLER: Objection. Objection to the word "safe."
A. I would have to answer that question that I think that everything has a risk associated with it. And the risk is what you want to take. And that risk is whether you're walking down the sidewalk or driving on the street or eating saturated fats or any other area.
Q. (By Mr. Scruggs) Do you think, then --
A. There is a risk of breathing air.
MR. SHEFFLER: Let him finish his answer.
MR. SCRUGGS: I thought he was.
Q. (By Mr. Scruggs) Are you finished?
A. I think.
Q. Do you think there is a risk of bronchogenic carcinoma in humans that smoke?
A. Sure. There is a risk in bronchogenic carcinoma in individuals who don't smoke.
Q. Do you think smoking increases the risk of carcinoma in humans?

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A. Sure.
Q. Do you think the risk increases with the amount of tobacco you smoke?
A. Probably.
Q. Do you also think that the risk of emphysema is greater in people who smoke?
A. Probably.
Q. And that that risk increases with the amount that is smoked?
A. Probably.
Q. Same for COPD?
A. Sure.
Q. Is smoking associated with any other health effects in humans, other than COPD, emphysema and lung cancer?
A. You have to get in the whole question of arthrosclerotic disease --
Q. Is smoke --
A. -- coronary artery disease, strokes and all those other things. I think the association there is also fairly clear.
Q. With smoking?
A. Yes, sir. That's what we were talking about.
Q. Would the risk of those conditions also increase with the amount that's smoked?

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A. Sure.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, let's go over Exhibit 2, which is your, what we call 26-B4 statement.

A. Okay.

Q. It says here that you're going to discuss at trial the diagnosis, treatment and clinical course of cancer, urinary tract disease and respiratory disease. Are you an expert in the diagnosis and treatment in the clinical course of cancer?

A. To the extent that any other internist is.

Q. Do you have a special expertise in the diagnosis, treatment and clinical course of bronchogenic carcinoma over and above what another internist would have?

A. No.

MR. SHEFFLER: Objection to the characterization of Dr. Reinarz as an ordinary internist.

A. With the rank of fellow professor.

Q. (By Mr. Scruggs) What do you intend to say about the diagnosis, treatment and clinical course of cancer?

A. Oh, my --

MR. SHEFFLER: Objection to the --

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A. I'll be happy to answer any question you've got that I can --

Q. (By Mr. Scruggs) I just asked you one.

A. -- within my expertise.

Q. Do you routinely diagnose and treat patients with bronchogenic carcinoma?

A. I routinely diagnose them.

Q. Do you? What are the signs and symptoms of bronchogenic carcinoma?

A. The signs and symptoms of bronchogenic carcinoma vary from no symptoms whatsoever to deader than a doornail. Now, if the question you're asking me is what signs and symptoms are present at the time a patient becomes symptomatic of their tumor, I can describe the symptoms that are being described in the textbooks. But depending on how adroit one is and how lucky one is, you may diagnose one in a very early stage, or you may not diagnose it until autopsy.

Q. Well, what other factors do you use, Doctor, that you consider in evaluating a patient for bronchogenic carcinoma?

A. That's much too broad a question to answer.

Q. Is smoking history one of the things you look for?

A. It's one of the things I look for, but not as one of

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the primary issues of whether or not there's a tumor.

(Discussion off the record.)

Q. (By Mr. Scruggs) Doctor, you're -- is it not true you intend to be called as an expert witness in this case?

A. I believe I will.

Q. What are you going to generally discuss? What are you going to say to the jury in this case --

A. I'm going to answer --

MR. SHEFFLER: Objection.

MR. SCRUGGS: No, no.

MR. SHEFFLER: Objection to the form of the question.

MR. BARRETT: He hasn't finished the question.

MR. SHEFFLER: He did finish the question. I'm sorry, didn't you finish?

MR. SCRUGGS: No, I hadn't finished the question.

Q. (By Mr. Scruggs) What are you going to say with regard to the diagnosis, treatment and clinical course of cancer? What are you going to say about that?

MR. SHEFFLER: Is that the extent of

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the question?

MR. SCRUGGS: Yes.

MR. SHEFFLER: I object to the question. Obviously he cannot sit here today and tell you the answers to the questions that I or anyone else poses to him at trial. You know that as well as I do.

MR. UPSHAW: You know he's going to answer the questions propounded on direct, he's going to answer the questions propounded on cross, he's going to answer the questions propounded on redirect, and that's what he's going to say.

MR. BARRETT: And the first question is going to be, "Dr. Reinarz, tell us about the diagnosis, treatment and clinical course of cancer?" It's right here on --

MR. UPSHAW: That's not going to be my first question.

MR. SHEFFLER: If that's the first question you pose, it will be objected to, and I imagine the objection will be sustained.

MR. BARRETT: He's going to answer it.

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MR. SHEFFLER: He said he's going to generally discuss it. Let's get the record straight one last time. These expert reports are really answers to interrogatories under which we were required to tell you in summary fashion the general scope of the witness' expertise, the scope of his opinions and the basis thereof. And that's exactly what we did. There is no intent to have this as a representation of any testimony verbatim or otherwise that the witness will give at trial. And it wasn't meant to be that. With that understanding, you can ask any questions you want on it.

MR. SCRUGGS: I just did.

MR. SHEFFLER: And I objected to it.

MR. SCRUGGS: All right. He hasn't answered anything.

THE WITNESS: Well, would you ask the question?

Q. (By Mr. Scruggs) Doctor, at trial, in your statement it says, "Dr. Reinarz will generally discuss the diagnosis, treatment and clinical course of cancer." I'm asking you what are you going to generally discuss about each of those things,

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diagnosis, treatment and clinical course of cancer?

MR. SHEFFLER: If you can answer what the questions will --

Q. (By Mr. Scruggs) Are you going to talk about the etiology of cancer?

A. Only if you ask it, sir.

Q. All right. What is the etiology of bronchogenic carcinoma in humans?

MR. SHEFFLER: Asked and answered.

A. I don't know.

Q. (By Mr. Scruggs) You don't know?

(Discussion off the record.)

Q. (By Mr. Scruggs) Tell me what you're going to generally discuss about the diagnosis, treatment and clinical course of cancer?

MR. SHEFFLER: Objection, asked and answered.

MR. SCRUGGS: You've objected.

Q. (By Mr. Scruggs) Now what's your answer?

A. The answer is I will answer any relevant questions pertaining to this, in the case of Mr. Smith, that are addressed to me in my capacity as an expert witness.

Q. Doctor, did you tell me earlier that you had consulted with Mr. Sheffler for approximately 20 to

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24 hours about this case?
A. I don't remember what I said.
Q. Is that a fair statement?
A. Yeah.
Q. Did you not discuss your potential testimony at this trial with Mr. Sheffler during that 24-hour period of time?
A. I don't think we've discussed testimony in trial at all.
Q. Testimony anywhere?
A. If we discussed the kind of questions I might be asked and what the opinions I might have, the answer is yes. But if you think for one moment that he's told me what my opinions are, you've got another thing coming.
Q. Doctor, that's not what I asked you or what I'm suggesting. I'm asking you to tell me what you're going to generally discuss about the diagnosis of cancer?

MR. SHEFFLER: For the the last time, I object. Object, asked and answered.

A. I'll answer --
Q. (By Mr. Scruggs) Are you going to go over the factors that you use in diagnosing cancer?
A. If they're asked.

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Q. What are they?
A. What kind of cancer? What kind --
Q. Bronchogenic carcinoma, Doctor. Squamous cell carcinoma.
MR. SHEFFLER: Asked and answered.
Q. (By Mr. Scruggs) It's true. You told me it depends on a lot of things.
A. You've got to put it in the context of the frame work and not ask a general question. I'm not going to discuss a bowling ball either.
Q. Doctor, it's your words --
MR. SHEFFLER: No, it's my words.
Q. (By Mr. Scruggs) -- that you are going to generally discuss the diagnosis of cancer. What are you going to generally say about the diagnosis of cancer?
MR. SHEFFLER: Object. This is a word I said on the answer to -- **these are answers to interrogatories, as you well know, prepared by the counsel for American Tobacco.** They are not to be the representation of the testimony that he may be called to give at trial verbatim. So I object once more to the mischaracterization of the witness' testimony.
Q. (By Mr. Scruggs) Would you answer my question,

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Doctor?

A. Which is what?

Q. It says you will generally discuss the diagnosis of cancer. What are you going to say? What are you going to generally discuss?

MR. SHEFFLER: Objection, asked and answered.

A. I've answered that at least three times.

Q. (By Mr. Scruggs) Well, then it should be very easy to do again.

MR. SHEFFLER: You're not going to ask him to do it three times. Objection, Dick. Answer it one more time.

(Discussion off the record.)

Q. (By Mr. Scruggs) What are you going to say about the treatment of cancer, Doctor? How do you treat your cancer patients?

THE WITNESS: Is he baiting me?

MR. SHEFFLER: He's asking you, Doctor, for the -- if you can answer the question, Doctor, please do so.

Q. (By Mr. Scruggs) How do you treat your cancer patients, medically treat them?

A. How do I?

Q. Yes.

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A. I refer them to an oncologist. I refer them to a radiation oncologist. I get opinions. I discuss it with my patients and we elect a course of therapy, and it may include anything from resection to radiation to chemotherapy to some combination of those. And all of those are acceptable forms of treatment of lung cancer or any other cancer.

Q. Doctor, what would you have recommended to Anderson Smith had he presented to you with the signs and symptoms that he had of lung cancer that you read in his records?

A. When would he present, sir?

Q. At the time he was diagnosed.

A. At the time we had a biopsy diagnosis?

Q. Yes.

A. I don't know. I would have to think on that just a little bit. The question posed to me to this point wasn't to do things differently, but to critique the way it was done.

Q. All right. Did you see anything --

A. And to try to understand what was done.

Q. Okay, Doctor.

A. I don't --

Q. Do you agree or disagree with the treatment that Mr. Smith received for his bronchogenic carcinoma?

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A. I have no reason to disagree with it. I mean, I think reasonable people made the diagnosis, and I think reasonable people considered options, and I think reasonable people began a course of therapy. And they were a lot better qualified based on seeing him, taking care of him, all the things they had available, to prescribe the form of therapy they had. And I would not try to second guess them on that.

Q. You have no criticism of the treatment that Mr. Smith received for his lung cancer?

MR. SHEFFLER: He's asking if you recall specifically anything in the records that you reviewed what about his treatment that you disagree with.

A. It's really not funny, because you're asking an all-inclusive question in a very complex record with a man of multiplicity of different problems. And it's just not that simple to say I buy off on every aspect of it. And you would be the very first one to come down and criticize me if I did.

Q. (By Mr. Scruggs) Doctor, I'm asking you --

MR. SHEFFLER: That's what he's trying to do, Doctor.

MR. SCRUGGS: I'm not trying to do

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anything, I'm just trying to get some answers.

A. Well, the answers are not that simple. And I will answer the question you ask by saying that from the context in which I reviewed -- I was not reviewing that record to make further recommendations for treating a man who is already dead. And I didn't think about it in that context. I thought about it in terms of alternative diagnosis and what were the events leading up to the means that this man died.

Q. (By Mr. Scruggs) Were there any alternative diagnoses of bronchogenic carcinoma that you would have entertained had you reviewed the records --

A. You bet. Among other things, he had something going on in his prostate and he had something going on in his bladder. And we still to this day don't know what those are.

Q. Doctor, we're dealing with this sentence here that says you will discuss generally the diagnosis, treatment and clinical course of cancer.

A. Bingo. We've been doing that.

Q. I'm talking about his bronchogenic carcinoma.

A. You are. You're talking about cancer. You asked me earlier in this deposition did I think he could have one somewhere else.

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Q. No, sir, I asked you if you thought beyond a reasonable degree of medical probability did he have one somewhere else?

A. I said I think he probably did.

Q. Do you think it's probably more likely than not that Mr. Smith had a cancer outside of his lungs?

A. I think it's a very reasonable possibility.

MR. UPSHAW: Let's take a little short break.

(Brief recess.)

Q. (By Mr. Scruggs) Doctor, did you talk with your lawyers during the break?

A. Yeah.

Q. Which ones did you talk to?

A. That one, that one and that one.

Q. Mr. Sheffler --

MR. UPSHAW: I'm the one that told him not to be pissed off at you, if that's what you want to know.

Q. (By Mr. Scruggs) Other than advising you not to get mad at me, what else did you discuss with them?

A. That's really it.

MR. UPSHAW: I think he did say he had to go to the restroom.

Q. (By Mr. Scruggs) Let's leave off where we were.

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You said it was more likely than not that Mr. Smith had a urinary tract cancer, based on your review of his records?

A. I think he did.

Q. More likely than not --

A. His doctors did, too.

Q. All right. I'm asking your opinion. Is it more likely than not -- that's the legal standard. Is it more likely than not he had a urinary tract cancer?

A. I think he probably did.

Q. "Probably" means more likely than not?

A. Yes.

MR. UPSHAW: That's clear.

MR. SCRUGGS: It is to me. I want to make sure it is to him.

MR. UPSHAW: Okay. Go ahead.

Q. (By Mr. Scruggs) What leads you to believe, Doctor, what can you point to in those records that you looked at that leads you to believe he had a urinary tract cancer?

A. Basically the description that they made of the thing when they did the cystoscopy.

Q. Let's go to that. Show me where that description is.

THE WITNESS: Can I continue to

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answer while he's looking for that?

MR. SHEFFLER: No.

MR. BARRETT: Your lawyer says no.

It would be okay with us.

A. Well, he had a long history of having recurrent obstructions and surgery to relieve the areas of obstruction. And he had chronic inflammation and infection there and he was obstructing, and when they looked in there, they found that papillomatous lesion. A papillomatous lesion looks a lot like a cauliflower, and while it could be an inflammatory process in an older man who had longstanding problems, that if that had been me, had they told me everything that they found on him, I would have expected to come back with a biopsy report of carcinoma. I would have prepared myself for that.

Q. (By Mr. Scruggs) Okay. Doctor, show me the records that you're relying on for your opinion that the gentleman --

A. It's really the composite of the obstructions that were made in here. How about this part, for example?

Q. Give us the page number.

A. 0183. And I'll read the record. "Trigone erythematous and edematous and appeared to be

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replaced with tumor."

Q. All right. Doctor, are all tumors cancerous?

A. No, but most of them in the urinary tract are.

Q. Was a biopsy performed on that tumor?

A. Yes, it was.

Q. And what were the results of the biopsy?

A. The results of the tissue that was obtained was negative.

Q. Negative for cancer?

A. Yeah.

Q. Do you routinely diagnose cancer in the face of a negative biopsy, Doctor?

A. Negative biopsy by no means excludes it, especially if there is scarring around it. If you're clinical suspicion is indicative of it, you go in and get another biopsy. In this particular instance, the biopsy of the thing showed that there was mucosal dysplasia, moderate. And then it said tissue inadequate for prostatic evaluation.

MR. SCRUGGS: Let's mark this as Exhibit 6.

(Reinarz Deposition Exhibit No. 6 marked for identification.)

Q. (By Mr. Scruggs) Is it your testimony that Mr. Smith had cancer of the prostate?

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A. No, sir, I haven't said that.
Q. No, I'm just asking, because that's --
A. I said I think it is quite likely that he had cancer of the prostate or trigone or his bladder or both. And if that were you, Mr. Scruggs, I would go back in and ask they rebiopsy that area.
Q. Doctor, I'm certain that you would.
A. Because I care about you.
Q. That's all I've ever wanted, Doctor, was a doctor who cared. Other than the negative biopsy that should, in your opinion, have been repeated, the obstruction of his urinary tract and the inflammation of his urinary tract, which he had many --

MR. SHEFFLER: Do you have to do something about that?

THE WITNESS: I'll wait a few minutes.

Q. (By Mr. Scruggs) Other than those factors, what else leads you to believe he had a urinary --
A. The cystoscopic appearance of it. It says it looks like tumor.
Q. But you said, Doctor, that all tumors are not cancerous, are they?
A. No. But I also said that tumors in the urinary

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tract usually are.

Q. Was this tumor biopsied?

A. I don't know what was biopsied. I do know that something was biopsied through that cystoscope. But if you've ever watched biopsies through a cystoscope with a bleeding base, you sort of blindly go in and take a hunk of tissue. If you have a diagnosis from that, you can make a definitive statement. If you don't have a diagnosis, then you've got to go back in and rebiopsy. I think even the histology that showed moderate dysplasia would indicate that that area alone required rebiopsy, the margin of it.

Q. Would you have rebiopsied this gentleman?

A. If he lived long enough.

Q. I'm saying would you rebiopsy him in the face of this report, Exhibit 6?

A. Yeah, yeah.

Q. Why would you have done that when you can diagnose him with cancer without it, as you're doing now?

MR. SHEFFLER: Objection. That's not what he did.

MR. UPSHAW: He said most likely.

A. I think the burden is to exclude a treatable lesion, in this case a cancer, cancer of the prostate, cancer of the bladder, which should have a good

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prognosis in this man if it were diagnosed early.

Q. (By Mr. Scruggs) When do you think Mr. Smith developed cancer of his urinary tract?

A. I can't answer that.

Q. You can't answer that based on his records?

A. If you're asking me when did the first cell appear that was a malignant cell that was setting forth the events that I think probably resulted in cancer, I don't know. My guess would be at least several years.

Q. Do you think Mr. Smith then had a diagnosable cancer for several years prior to his diagnosis? And I'm talking about bladder cancer.

A. Depends on how you're diagnosing him. Quite obviously it was not diagnosed by the cystoscopy thing they did at this time. Was it diagnosable had he been hit by a car and gone to autopsy? Yes.

Q. Doctor, do you believe that the urinary tract cancer of Mr. Smith was associated in any way with his squamous cell carcinoma in his right lung?

A. Most indirectly. I think they were probably two independent variables.

Q. Do you think they were independent cancers?

A. Yeah.

Q. Is it your opinion that the squamous cell carcinoma

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in Mr. Smith's right lung was not a metastatic cancer from his prostatic cancer?

A. I don't think it was.

Q. Assuming that Mr. Smith did in fact, as you believe, have urinary tract cancer, what would have been his prognosis?

A. Well --

MR. SHEFFLER: Objection. I object to the question --

MR. UPSHAW: Hell, he died.

MR. SHEFFLER: Would you read that question back, please?

Q. (By Mr. Scruggs) What's the normal prognosis -- I'll rephrase it. What's the normal prognosis in a man who is diagnosed with urinary tract cancer that Mr. Smith had?

A. It's regarded as high variable, and it's highly variable depending on the cell type what the organ of origin is.

Q. Can you tell the cell type of cancer Mr. Smith had from anything you've seen?

A. I wasn't through answering the question.

Q. I beg your pardon.

A. In that in large part, it would depend whether it was from the prostate or from the bladder. Bladder

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cancers tend to be really pretty invasive and they have a poor prognosis. Prostatic cancers, on the other hand, if they are locally contained within the area, have a reasonably good prognosis.

Q. **Doctor, did Mr. Smith, in your opinion, have both a bladder and a prostatic cancer?**

A. **I can't say from the record.** I can't tell whether he may have had one or the other or one which is eroding into the other. He could have had a prostatic cancer which was eroding into his bladder trigone, because they sit there proximate to one another. And that's one of the critical reasons why you need a cell type.

Q. Doctor --

A. Wait a minute. I'm still answering the question. Carcinoma of the bladder is usually the transitional cell, epethelial type, and the ones of the prostate are usually of the prostatic glandular type. The one of the prostate are very frequently dependent on having an androgen present. And a simple archiectomy would deprive the tumor of androgen and frequently arrest its growth.

Q. Can you say within a reasonable degree of medical probability that Mr. Smith had a bladder cancer?

A. Let me answer it this way: The doctors taking care

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of him thought that that was a high probability item or they wouldn't have done the cystoscopy and the biopsies of that. They thought from all the information they had, which is what I have plus some, that it was there. They did the biopsies for that purpose. I'm sure they didn't do it because they had nothing else to do that day. They thought it was real important to his health.

Q. Doctor --

A. And I agree with them.

Q. All right. I'm asking your opinion. Is it more likely than not that he had a bladder cancer --

A. I don't know --

Q. -- as opposed to a prostatic --

A. He had a bladder cancer, but I think there were enough red flags that a bladder cancer may be present to cause his doctors to biopsy that area. And I think there is enough information following the biopsy to indicate another biopsy based on the results that they got.

Now, there is not enough information to initiate a treatment program. And since the treatment program may have all the way from radiation to that area to excision of his bladder to archiectomy, to chemotherapy, it is absolutely critical that that be

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diagnosed.

Let me make a comment. I have had a number of patients who you suspect cancer in and the biopsies are negative. And if you persevere, you can find it on the second or third biopsy.

The clearest example of that was with my secretary who had a father who has esophageal stricture. And his esophageal stricture was very much like this man's urethra stricture. And it would dilate and give him relief. And he was biopsied seven or eight times, all of which showed nothing. But we persevered and finally found the tumor. The tumor was bound up in the scarring cicatrix. So the answer does that biopsy exclude that, absolutely not.

MR. SHEFFLER: It's now 6:00 o'clock, Mr. Scruggs. Do you have much more along this line of questioning?

MR. SCRUGGS: Yeah.

Q. (By Mr. Scruggs) Doctor, in Exhibit 1, there are a number of pages that have a green highlight. Are you aware of that?

A. Yes.

Q. Are you the one that placed those highlights in there?

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A. Yes.
Q. Did you do it for a purpose?
A. Sometimes. If you ask me what the purpose was, generally speaking, I was generally highlighting things that I thought may be of value to me. But it was like reading a novel in that I didn't know the answer. So that -- I mean, I didn't go back and note -- come back and change my highlights or anything else. For some reason, it was important to me. I'll be happy to go over any green highlight you find and try to tell you as best I can what it meant to me at the time.

MR. SCRUGGS: You want to break for the day?

(Discussion off the record.)

Q. (By Mr. Scruggs) Did you make any other notes, Doctor, besides the highlighting with respect to the medical records in Exhibit 1?
A. **No. I stuffed it all in my head.**

MR. SCRUGGS: You want to keep going or not?

MR. SHEFFLER: If this is a convenient place to stop, if we're going to resume tomorrow, why don't we do that.

(Depositioned adjourned.)

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ORAL DEPOSITION OF JAMES ALLEN PEINADO, M.D.

CHANGE CORRECTION PAGE

Please indicate changes on this sheet of paper, giving the page and line number, the change and the reason for the changes. Reason for changes are: (1) To clarify the record; (2) To conform to the facts; (3) To correct transcription errors.

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SIGNATURE OF JAMES ALLEN REINARZ, M.D.

I have read the foregoing transcript of my deposition taken on the 9th day of February, 1993, and it is a true and accurate record of my testimony given at that time and place, except as to any corrections I have listed on Page _____ herein.

_____
JAMES ALLEN REINARZ, M.D.

THE STATE OF TEXAS)
COUNTY OF HARRIS)

SUBSCRIBED AND SWORN TO BEFORE ME, the undersigned authority, on this the _____ day of _____, 19__.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF T E X A S

MY COMMISSION EXPIRES:

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IN THE CIRCUIT COURT OF WASHINGTON COUNTY, MISSISSIPPI

JEANETTE WILKS, DAUGHTER OF ANDERSON SMITH, DECEASED, INDIVIDUALLY, AND ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES AND THE ESTATE OF ANDERSON SMITH, DECEASED *

Vs. *

THE AMERICAN TOBACCO COMPANY AND NEW DEAL TOBACCO AND CANDY, INC. *

CIVIL ACTION
FILE NO. 91-12,355(b)(w)

REPORTER'S CERTIFICATION
ORAL DEPOSITION OF JAMES ALLEN REINZARD, M.D.
TAKEN FEBRUARY 9, 1993

I, Linda Tate, Certified Shorthand Reporter in and for the State of Texas, hereby certify that this deposition transcript is a true record of the testimony given by the witness named herein, after said witness was duly sworn by me.

I further certify that I am neither attorney nor counsel for, related to, nor employed by any of the parties to the action in which this testimony was taken. Further, I am not a relative nor employee of any attorney of record in this cause, nor do I have a financial interest in this action.

Further certification requirements pursuant to the Rules will be certified to after they have occurred.

Subscribed and sworn to on this the _____ day of _____, 1993.

Linda Tate, CSR
CSR Certification No: 2965
Expiration Date: 12-31-93

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IN THE CIRCUIT COURT OF WASHINGTON COUNTY, MISSISSIPPI

JEANETTE WILKS, DAUGHTER OF ANDERSON SMITH, DECEASED, INDIVIDUALLY, AND ON BEHALF OF ALL WRONGFUL DEATH BENEFICIARIES AND THE ESTATE OF ANDERSON SMITH, DECEASED	*	CIVIL ACTION FILE NO. 91-12,355(b)(w)
Vs.	*	
THE AMERICAN TOBACCO COMPANY AND NEW DEAL TOBACCO AND CANDY, INC.	*	

CERTIFICATE TO THE ORAL DEPOSITION OF
JAMES ALLEN REINARZ, M.D.
TAKEN FEBRUARY 9, 1993

I, LINDA A. TATE, a Certified Shorthand Reporter in and for the State of Texas, hereby certify pursuant to the Federal Rules and/or agreement of the parties present to the following:

That this deposition transcript is a true record of the testimony given by the witness named herein, after said witness was duly sworn by me;

That the original deposition transcript was submitted on _____ to the witness and/or through the witness' attorney of record for examination, signature, and return to SOUTHWEST REPORTING SERVICE, INC., by _____;

That the original deposition transcript was ___ was not ___ returned to the deposition officer by the specified date. All changes made by the witness, if any, are attached hereto;

That on _____, the original deposition transcript, or a copy thereof, together with copies of any exhibits was delivered to the custodial attorney, attorney for _____;

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes all parties of record:

MNAT 00023499

MR. RICHARD SCRUGGS, Attorney for the Plaintiffs;

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MR. DON BARRETT, Attorney for the Plaintiffs;
MS. CYNTHIA LOTT, Attorney for the Plaintiffs;
MR. BRUCE SHEFFLER, Attorney for American Tobacco;
MR. LONNIE BAILEY, Attorney for American Tobacco;
MR. J. MURRAY AKERS, Attorney for New Deal;

That a copy of this certificate was served on all parties shown herein.

Given under my hand and seal of office on this the _____ day of _____, 19__.

LINDA A. TATE
C.S.R. Certificate No. 2965
Expiration Date: 12-31-93

Linda A. Tate
Notary Public in and for the State of Texas
My Commission expires: 6/27/93

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